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degree of Doctorate in Clinical Psychology**

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Section**

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**Seeking to understand: The conceptualisation and impact of attitudinal beliefs  
about mental health within a lay population**

Karen Gurney

Abstract

Prior research has outlined the presence of stigmatising opinions towards people experiencing psychological distress within the general population in UK society. These stigmatising opinions may result in the discrimination of a person in receipt of psychological services. Previous research has highlighted the adverse effect that stigmatising beliefs may have on a person experiencing psychological distress in terms of social exclusion, increased symptomatology and lowered self-esteem. To date, attempts to document the contributing factors to such attitudes have been largely speculative.

The aim of this study was to gain insight into how members of the general population conceptualised their attitudes towards mental health, and identify factors that they perceived to be influential in the development of these attitudes. In particular, the role of the family in this process was considered to be of importance. The present study focused on the accounts of family dyads, one generation apart, to aim to develop this understanding further.

Using grounded theory methodology, transcripts of interviews with seven participants were analysed and a model was developed to represent the process of developing an understanding about mental health. This model was characterised by the fluid core category of 'Seeking to Understand' and demonstrated a process of evaluation of a 'mentally ill' person.

The core category and six main categories are discussed in relation to the literature. A review of the methodology and reflections on the research process are provided. It is suggested that clinicians should consider the influence of client's beliefs about mental health prior to beginning therapy. The implications of considering family, clinical training and wider societal systems are also considered.

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## 1. Introduction

### **1.1 Overview of Chapter**

In this section the researcher will present the factors which led to an interest in conducting research in this area. The reasoning for, and the potential disadvantages of the terminology used in the study will be acknowledged alongside the consideration that this language has the potential to validate current stigmatisation further. A broad review of the literature and the considerations leading to the chosen research question will provide the reader with a grounding in the general area of discussion. Finally, the reasons for using qualitative methodology, in particular grounded theory, to address the research question will be outlined.

### **1.2 Presenting the researcher's interest in this area**

The researcher was intrigued by the attitudes of others when learning of her chosen profession and the language used generally to refer to issues relating to mental health. Terms such as 'nervous breakdown' seemed to arise frequently in those without any specialist training in this area. Similarly, a general lack of understanding appeared to signify that the subject of psychology and its application were observed to be largely mystified within the general public. The researcher wondered whether these factors contributed to stigmatisation and the subsequent reluctance of those experiencing psychological distress to engage in help seeking behaviours.

### **1.3 Use of language**

The researcher acknowledges that the use of the term 'mental illness' carries with it assumptions of subscription to the medical model, alongside potential implications about recovery and causality. Furthermore, it is a term generally laden with stereotyping and stigmatisation in UK society. The researcher recognises that there is a chance that the use of this terminology presents an image of acceptability and

colludes with these processes without intention. This aside, an appreciation that despite the care taken within the field of clinical psychology to use non-pejorative terminology without the prescriptions of labels adhering to the philosophy of the medical model, a hypothesis that this is not usual practice within the general population was accepted. For this reason the use of terminology such as 'mental health' and 'mental illness' will be used throughout this thesis.

## **1.4 Review of the literature: Stigmatising attitudes about mental illness within the general population**

Attitudes are learned or acquired concepts consisting of related cognitive, affective and conative components (Lopez, 1991). In this sense they can be viewed as having an evaluatory component in which the person relates to another, or an object, on a continuum from positive to negative. The consequences of widespread negative attitudinal beliefs about a population may result in stigma, described by Goffman (1993) as 'the situation of the individual who is disqualified from full social acceptance.'

Stigmatising attitudes about mental illness within the general public have been found to be predominantly negative and widespread. The impact of negative stereotypes and discrimination on people with a diagnosis of mental illness promotes the need for further understanding of the origins and maintenance of such stereotypes, with an aim to aiding health promotion and combating discrimination. Individual differences in culture, gender and age have been found to have an impact on negative attitudes to people with mental health problems, and several authors have suggested factors contributing to the origins of such attitudes.

In a nation where one in four people will experience some kind of mental health problem in the course of a year (Goldberg & Huxley, 1991), and where around a quarter of all drugs prescribed by the NHS are for mental health problems (Department of Health, 1996), it is paradoxical that people diagnosed with a mental illness should still be vulnerable to widespread stigmatisation, discrimination, and

exclusion by the rest of society. It has been estimated that by 2020, depression will be second to chronic heart disease as an international health burden, causing disability, incapacity to work and a drain on medical resources (Prescriptions Pricing Authority, 1998), yet evidence suggests that one in three people have not felt able to consult a professional about their mental health difficulties (Mann, 1998).

So why the continuing perception of mental illness as a mystical and frightening concept, how do these stigmatising opinions originate, and what effect do commonly held stereotypes have on those with a diagnosis? In this chapter the researcher will attempt to clarify what is known about stigma, and outline how its clinical relevance promotes the need for further action.

## **1.5 What is Stigma?**

The term stigma historically refers to *'any attribute, trait or disorder that marks an individual as being unacceptably different from the 'normal people' with whom she/he routinely interacts, and that elicits some form of community sanction'* Goffman (1963; p 23). Gilbert (2000) suggests there is a natural human propensity to stigmatise those who are different and that disabilities in themselves are not invariably stigmatising, but rather the idiosyncratic opinions that society holds about them. Ideas concerning aetiology, culpability, predicted behaviour, perceived dangerousness and unpredictability contribute to the maintenance of stereotypes of mental illness in the general public.

The functions behind stigmatising behaviour have been theorised by many authors and are too comprehensive to be included in this review. However, they are perceived to serve evolutionary purposes (Gilbert, 2001), cover socio-cultural perspectives (Corrigan et al, 2000), motivational biases (Corrigan et al, 2000) and social cognitive theories (Corrigan, 1998; Crocker & Lutsky, 1986). Social cognitive theories understand stigmatising attitudes as knowledge structures developing from community experience and are the focus of this research as they provide a rich theoretical base and intervention approach for challenging stigmatising attitudes at

societal level (Hilton & von-Hippel, 1996; Krueger, 1996; Mullen, Rozell, & Johnson, 1996)

A substantial body of research over the years has identified a shroud of negative attitudes pertaining to persons with a disability (Chubon, 1982; Gorden, Minnes & Holden, 1990; Yuker & Block, 1986). Furthermore, evidence suggests that the most devalued of all persons with 'disabilities' so far as society wanting to distance itself from them are those with a mental illness (Bowman, 1987; Socall & Holtgraves, 1992; Steinwachs et al., 1992).

Research indicates that the term mental illness encourages images of people who are unpredictable, unreliable, unlikeable, incompetent and bizarre (Bhugra, 1987; Mansouri & Dowell, 1989; Socall & Holtgraves, 1992). Perhaps the most damaging commonly held stereotype is the perceived correlation with mental health problems and violent behaviour (Dowbiggin, 1988; Link, 1987; Steinwachs et al, 1992) despite evidence that this picture is highly inaccurate (Retzinger, 1990; Townsend, 1990).

## **1.6 Implications of stigma for persons with a diagnosis of mental illness**

Research into the incidence, origins and amenability of stigmatising opinions in the public is clinically relevant due to its powerful effects on those with a diagnosis of mental illness. The adverse consequences of stigmatisation are countless. They range from decreased employment and housing opportunities (Farina & Felner, 1973; Link, 1982; Page, 1977; Wahl & Harman, 1989; Marrone, Balzell & Gold, 1996) increased stress within the family (Wahl & Harman, 1989; DePonte, 2000), social exclusion (Farina et al, 1974; Read & Baker, 1996), increased depression and anxiety (Birchwood et al, 1993; Link et al, 1997; Farina et al, 1981), low self esteem (Link et al, 2001; Link, 1987) and social withdrawal and avoidance (Link et al, 1989). It can be predicted that stigma has a detrimental effect on persons with a mental illness, exacerbates difficulties in being accepted by the community, and may, by a combination of ambient psychosocial stress and lowered self esteem, increase the likelihood of future relapse or serve as a barrier to recovery.

Suggestions about the stigmatising effects of a diagnosis of mental illness on the severity of the persons' difficulties are known collectively as 'labelling hypothesis' (Scheff, 1963; Link et al, 1990). The theory suggests that the cultural stereotype of mental illness act as a self-fulfilling prophecy in that others react to the individual in a uniform way that encourages the person to 'act out' the expected role, thus validating the original stereotype. The extent to which this theory has a clinical basis, if at all, is unknown, but what is clear is the further detrimental effect that negative stereotypes and stigmatising labels have on an individual with mental health problems. Gilbert (2001) also acknowledges the effect that the act of concealment resulting from fear of stigmatisation can have in interfering with interpersonal behaviour and maintaining negative self-evaluations (Pennebaker 1997; Smart & Wegner, 1999).

## **1.7 Prevalence of stigmatising opinions in the general public**

Large volumes of research suggest that the general public holds general antipathy towards the mentally ill (Philo, 1996; Farina & Burns, 1984; Page, 1997; Wolff et al, 1996). Research has also demonstrated that these stigmatising attitudes towards people with a mental illness are widespread (Byrne, 1997; Link et al, 1997; Jorm et al, 1999) and are commonly held (Rabkin, 1974; Heginbotham, 1998; Porter, 1998).

Perhaps one of the largest surveys into public attitudes of mental illness is that carried out by Crisp (2000) on behalf of the Royal College of Psychiatrists entitled 'Changing Minds: Every Family in the Land'. The aim was to determine opinions of the British adult population as a baseline data for a campaign to combat stigmatisation. The survey focused on seven main categories of diagnosis; depression, schizophrenia, anxiety, dementia, eating disorders, alcohol misuse and drug addiction. One thousand seven hundred and thirty seven adults were chosen randomly by a national sample of postcode selection and completed questions relating to dangerousness, attribution of blame, ability to 'pull themselves together', response to treatment and prospect for recovery.

Schizophrenia, alcoholism and drug addiction elicited the most negative opinions as approximately 70% of respondents rated people with these conditions as dangerous to others and 80% rated them as unpredictable. People with a diagnosis of alcohol misuse and drug addiction were frequently rated as to blame for their disorders and 'capable of helping themselves', furthermore, there was a common and widespread view that people with any of the seven disorders are 'hard to talk to' and 'unpredictable'. Reactions to treatment show that most respondents were optimistic and accurate about prospects for improvement with treatment (although the type of treatment was not specified). More than one third of respondents felt that people with eating disorders could 'pull themselves together'.

## **1.8 Prevalence of stigmatising opinions in the helping professions**

Alongside the general public, health professionals have also been found to hold negative attitudes towards individuals with a diagnosis of mental illness (Townsend, 1990). The use of psychiatric labels has been conceptualised as a form of stereotyping in it's own right in the unstated assumption of homogeneity between diagnostic categories (Townsend, 1990; Griffiths & Hughes, 1993).

A significant and clinically relevant finding from a study by Jorm et al (1999) indicated that although both the public and health professionals held negative attitudes towards persons diagnosed with mental illness, on the whole, GPs, psychiatrists and clinical psychologists held more negative attitudes than the general public. Explanations for such findings could be that such professionals have contact with individuals with chronic or recurrent problems, possibly leading to overly pessimistic attitudes, and that health professionals may be more realistic with regards to long-term prognosis. Interestingly, the clinical psychologists taking part showed more favourable attitudes than the GPs and psychiatrists, particularly in the depression vignette, which the authors hypothesised to reflect the belief of psychologists in the effectiveness of therapeutic intervention on long-term outcome. This finding may suggest that optimism about prognosis may be in some way responsible for feelings about working with this client group.

## 1.9 Origins of stigmatising opinions

Attempts to clarify the *origins* of stigmatising opinions do not reflect the efforts that have been channelled into discovering the *degree* of stigmatising opinions held by the public. Yet these origins are undoubtedly a crucial factor in attempting to reduce stigma associated with mental health problems. It has been hypothesised that opinions are formed by inaccurate or insufficient knowledge gained from family and peers, lack of social contact/proximity to people with a diagnosis of mental illness, and negative media influences and reports (Wahl 1995; Scheff, 1966; Angermeyer & Matschinger, 1996).

### *Lack of Knowledge*

A study by Wolff et al (1996), attempted to test the hypothesis that negative attitudes to people with a mental illness may be fuelled by a lack of knowledge. Two hundred and fifteen people were interviewed, and three factors were extracted by factor analysis of the Community Attitudes Toward Mental Illness Inventory (CAMI). These were; Fear and exclusion, Social Control and Goodwill. The results showed that most respondents had some knowledge of mental illness and that the majority knew someone who had suffered from a mental illness.

However, there was a widespread belief that people with a mental illness were more aggressive (43%), and two thirds of respondents felt that other people would treat people with a mental illness negatively (usually by being wary or avoiding them). With regards to aetiology and culpability, 87% of respondents did not think that people were to blame for their mental illness.

The most commonly cited cause was environmental (83%). Other causes cited were hereditary (39%), organic causes (22%), accidents (11%) and substance abuse (21%). Most respondents (78%) felt that they would be able to tell if someone was mentally ill by their strange or odd behaviour (73%), odd speech (63%), the way they dress (32%), facial expressions (25%), or by their aggressive behaviour (24%).

Further support for this theory comes from a study by Reda (1996). She uncovered confusion in the general public regarding the nature of mental illness, showing a lack of understanding as to what type of disorder constitutes a mental illness (many participants believed that all persons with mental illness were psychotic). Participants classed learning difficulties as within the bracket of mental illness, and 49% of participants believed that a 'nervous breakdown' was different to mental illness. Hames & Welsh (2002) have also found that a great proportion of the public have confused ideas as to the meaning of the terminology used by mental health professionals.

In the nationwide study by Crisp (2000) participants' responses on treatment and recovery items suggest that the public's knowledge was of a fairly high standard. This casts some doubt over any significant correlation with lack of knowledge and negative stereotypes, and raises the possibility that other factors, may be responsible for the perpetuation of stigmatising beliefs. This supports findings of Byrne (1997) who found that in most cases, stigmatising opinions are not based on a lack of knowledge about mental illness.

### *Lack of social contact with people with a diagnosis*

Reda (1996) aimed to investigate whether casual contact with former psychiatric patients changes public perceptions of, and attitudes towards, persons with mental illnesses. This study ties in with the concept of a negative correlation between stigmatising opinions and degree of social contact or familiarity with someone diagnosed with a mental illness.

An experimental group and a control group of 100 participants were interviewed, on two occasions, six months apart. Immediately after the first interview, a residential facility was opened for former psychiatric patients in the study groups' neighbourhood. Reda predicted a positive attitude change among residents in close

proximity to the residents compared with the control group due to increased social contact leading to erosion of previously held stereotypes. However, at both interviews all participants expressed extremely negative views based on preconceived ideas that Reda has previously hypothesised are gained largely from the media (Reda, 1993).

As in previous studies, Reda identified several prominent negative attitudes. A sizeable proportion of respondents felt that people with mental illness showed poor communication (33%) and bizarre behaviour (30%), the latter being narrowed down to: 'living in a world of their own', 'going bezerk', 'looking vague', 'appearing muddled', 'having funny facial expressions with eyes sometimes rolling backwards', and 'wearing funny clothes'. Poor social skills, including 'being dirty', 'talking loudly', and showing lack of inhibition was mentioned by 25% of respondents, and aggressive behaviour was mentioned by 17% of participants. Participants reported that people with a mental illness were more likely to be carrying knives, shoplift, be rapists, and be of harm to children.

Similarly, in Crisp's study (2000), whether or not the respondent knew someone with a mental illness did not appear to have any effect on opinions and stereotypes. These findings contradict the theories of Link et al (2001), who suggest that it is lack of social contact or proximity with someone with mental health difficulties which maintains negative attitudes. Similarly, in Jorm's (1999) research into health professionals, having family or friends with a mental health problem was not significantly associated with attitudes in either direction, as was frequency of contact.

In both studies, response bias and sample bias may have been evident and influenced findings to some extent. However, the study still indicates heavily that proximity and opportunity to meet people with a past diagnosis of mental illness does not appear to have a significant effect on the widespread negative attitudes or inaccurate perceptions held by the general public.

## *Influence of negative media representation on stigmatisation of mental illness*

Reda (1993) hypothesised that television, radio and newspapers play an essential role in the public perception of mental illness. According to Link et al (2001), the portrayal of mental illness in the media is one of the primary contributors to developments of misconceptions, alongside peer relations and personal experience.

The media has been accused of being responsible for decades of ill informed and sensationalised news coverage pertaining to mental health issues. In 1997, a report by the Health Education Authority found that almost half of national press coverage during the previous year linked mental health problems to violence and criminality, although the vast majority of people with mental health problems are not violent (Ward, 1997).

A U.S. national research project investigating public attitudes found that the mass media was reported by the public as their primary source of information about mental illness, with TV and news coverage receiving 87% and families and friends just 51% (Robert Wood Johnson Foundation Programme on Chronic Mental Illness, 1990).

Perhaps the most sensationalised of all media representation of mental illness comes from the cinema. Byrne (1998b) argues that mental illness is the last prejudice that society has to confront in this medium, highlighting the ‘drooling maniacs’ of the cinema, such as Freddie Kruger, Dr Jekyll and Mr Hyde and Psycho. Byrne suggests that such representations perpetuate fears about the ‘unpredictability’, ‘dangerousness’, and the ‘split-personality nature’ of people with mental illness.

A study by Lawrie (2000) aimed to compare how newspapers report psychiatric and physical illness. They examined 213 articles over a period of one month, judging whether the result was essentially positive, negative or neutral, and whether there was a difference in the tone of the reporting between the two types of illnesses. The study found that 11% of the articles were positive (reporting clinical or research advances), 25% were neutral (giving a mixed or unclear message), and 64% were negative

(criticising standards of care). The research suggested that newspapers were more likely to criticise medical practitioners, but not medical patients, and this pattern was reversed in psychiatry with the bad press focused almost exclusively on those using psychiatric services. This research suggests issues of perceived culpability, as the underlying theme may be that persons with mental illness are seen to have a greater degree of control over their symptoms, and are therefore liable to be the target of blame.

Several researchers have found that 'bad press' relating to mental health reinforces stereotyping and stigmatising attitudes in the general public (Angermeyer & Mattschinger, 1996; Hammond, 1996). Research by Philo (1996: 23) highlighted the power of the media in developing beliefs, *'We have normally found that personal experience is a much stronger influence on beliefs than the messages which are given by the media. But in this research we found cases where this pattern was reversed. We found a number of cases (21% of sample) where people had non-violent experience which was apparently 'overlaid' by media influences. These people traced their beliefs mostly to violent portrayals in fiction or to news reporting.'*

If it is possible for media images to 'overlay' personal knowledge or experience of people with mental health problems as Philo suggests, there may be enormous ramifications with regards to the future increase in stigmatising attitudes towards the mentally ill by the general public. Media portrayal of mental illness is not necessarily becoming more politically correct or less graphic, and has actually shown open negativity to the concept of 'Care in the Community' (The Sun, 1998). A good indicator of the impact of the media may be to examine ideas about mental illness across generations as it could be argued that younger generations are more exposed to sensationalised media coverage and realistic cinematic experiences. Byrd (1989) suggests that gaining a better understanding of how attitudes develop may provide a basis for understanding how the media can be altered to provide more positive representations.

### *Individual differences and their effect on stigmatising attitudes*

As well as having a direct effect on public opinion, media coverage can also directly affect the confidence and self-esteem of people with mental health problems. The mind-body split in western thinking is both perpetuated within the media, and influences public attitudes and medical opinion. Perhaps this western idea of culpability creates a 'reluctance' to ascribe difficulties to the mind if mental health problems are seen as resulting from a 'lack of willpower' and are socially stigmatising. It has been suggested that individual differences in the tendency to stigmatise and hold negative stereotypes varies to a large extent with background, age, and gender. Each of these factors shall be considered in turn.

### *Cultural variations in stereotypes and stigmatisation*

Perceptions about cause, prognosis, and treatment of mental illness have been shown to vary across cultures and nations. Cross-cultural differences generally have differentiated between the internalisation (Africa and Asia) and externalisation (Australia, Europe and the US) of symptoms (Kagan, 1984; Ollendick et al, 1996). Similarly, traditional views of aetiology can vary from a consequence or punishment for sinful thoughts or deeds (Sheehan & Kroll, 1990), or a privileged spiritual gift to be celebrated depending on the norms of the culture and the status of the person in question (Ackernecht, 1943; Silverman, 1967).

In the study by Crisp (2000) 'Every Family in the Land', 95% of the respondents were white, and of British descent, questioning the generalisability of these findings to other ethnic and racial groups. This raises the interesting question of the degree of variance in the perception of mental illness across cultures and ethnicities within the general public in Britain. As mentioned earlier (Crisp, 2000), the degree and type of stigmatising opinions held about mental illness within non-white British members of society is largely unknown, as the large scale studies have involved white respondents in the majority. In the US, where research on this topic is also fairly limited, a study by Whalley (1997) attempted to discover whether ethnic and racial groups in the general population differed in the stigma they associate with mental illness. Using a

telephone survey, 1,507 participants from varying ethnic backgrounds (white, African-American, Hispanic, Asian and American Indian) were interviewed about the amount of contact, if any, they had with a person with a mental illness. They were also asked questions relating to perceived dangerousness, unpredictability, and other inaccurate stereotypes of behaviour usually associated with the stigmatisation of mental illness. These questions cover topics relating to both social contact, and knowledge.

The results supported the hypothesis that ethnic and cultural differences exist in the stigma associated with mental illness, as Asian and Hispanic respondents perceived people with mental health problems as significantly more dangerous than did white respondents. The clinical implications of this study, if it can be translated to the UK population, is that cultural factors may be an important consideration in public education campaigns about mental illness in general yet it seems this is an area that is fairly under researched.

### *Age differences and their impact on degree of stigmatisation*

In Crisp's (2000) research on behalf of the Royal College of Psychiatrists outlined earlier, an unusual trend in the relationship between the age of the participant and presence of stigmatising opinions became apparent. The findings indicate that stigmatising opinions are more frequent amongst younger people. Respondents aged over 65 were less likely to stigmatise against those with a diagnosis of schizophrenia and alcohol/drug misuse. This supports research by Yarney (1999), who found that stigmatising opinions about mental illness are more common among young people than older people. Similarly, Hainge (1997) found that young people have an image of people with mental health problems as 'violent, aggressive and old'.

If this research can be taken at face value it raises concerns for the future trend of stigmatisation and discrimination of people with mental health difficulties. Investigating this same trend in a vignette-based format, Norman & Malla (1983)

presented cases to 413 Canadian high school students with a modal age of 16. Each student was asked to comment on the individual presented in the case study with relation to aetiology, most appropriate method of treatment, perceived prognosis and preferred level of social distance. The three case studies were intended to describe paranoid schizophrenic, schizotypal personality disorder, and clinically non-significant behaviour. No psychiatric labels were presented with the vignettes. Research into general attitudes suggests a significant amount of preferred social distance to persons diagnosed with a mental illness amongst the teenagers. The authors also discovered that perceived severity of mental illness is positively related to attribution to physical causes, and negatively related to social acceptability. In addition, beliefs in psychosocial aetiology and psychosocial treatment correlate positively with optimistic beliefs about prognosis. This research has important clinical applications on two levels. Firstly, there has been great debate on whether educational campaigns should emphasise a medical or psychosocial model of mental illness in order to promote understanding and acceptance (Crocetti et al, 1972; Farina et al, 1978; Sarbin & Mancuso, 1970). Secondly, it raises concerns about the lack of understanding and potentially 'harmful' opinions developing in the younger generations.

It could be argued that it was a consequence of the participants' life-stage and lack of knowledge that resulted in the attitudes and opinions reported above. However, several authors have quoted adolescence as a critical stage in the developments of attitudes towards politics, religion, morality and mental health (Adelson, 1975; Fowler, 1976; Keniston, 1975; Kohlberg, 1976).

Previous research has highlighted the transmission of attitudes from parents to children on issues such as opinions towards institutional authority (Rigby, 1987). This study used quantitative measures and discovered similarities between the attitudes of parents and offspring with the presence of a 'generation gap', of which the impact of socialisation processes such as peer-group interaction, educational settings and media exposure are suggested to have had an influence. This supports the argument that parents are the primary forces on opinions, attitudes and behaviour (Santrock, 1990) but suggests that there are other factors influencing the development of their beliefs.

## *Gender differences in attitudes towards people with mental illness*

Gender differences in stigmatisation of the mentally ill has historically been an area in need of clarification. Some studies suggest that women are more accepting of mental illness than men (Farina et al, 1975; Farina et al, 1978), and others report to have not identified any significant difference between the sexes (Bord, 1971; Brockman & D'Arcy, 1978).

In the study of adolescents by Norman & Malla (1983), male and female respondents did not differ significantly in their tendency to perceive particular behaviours as being indicative of mental illness. However, female adolescents did show greater social acceptance of persons diagnosed with a mental illness than males, a finding consistent with earlier findings by Farina et al (1975, 1978). In further support of findings by Farina (1975;1978), Jorm (1999) found that female health professionals or members of the general public were more likely to rate positive outcomes for persons diagnosed with a mental illness.

### **1.10 Conclusions**

Most of the studies into the stigmatisation of people with mental health problems held by the general public have been large scale and as a consequence, quantitative in nature. Due to the nature of attempting to gain a 'snapshot' of opinions that are fairly generalisable, it has been necessary for authors to use postal and telephone surveys to span class, region of residence, and background. Large-scale investigations such as the one carried out by Crisp on behalf of the Royal College of Psychiatrists involve considerable time and resources and have provided a comprehensive view of current levels of stigmatisation across the UK.

Several studies have demonstrated that negative stigmatising attitudes towards mental illness are both inaccurate and widespread (Crisp, 2000; Retzinger, 1990; Townsend, 1990). There also appears to be a distinction between diagnostic categories with regard to people's opinions about dangerousness, blame, response to treatment and

prognosis (Crisp, 2000). The detrimental impact that these opinions have on a person with a diagnosis of mental illness appears fairly clear, and is suggested to include lowered self-esteem, increased social exclusion and disadvantage, and the self-fulfilling effects of the 'labelling hypothesis' prophecy. The clinical implications of this are wide reaching. To date, the origins of such opinions remain unknown, but are hypothesised to include the effects of lack of knowledge (Wolff et al. 1996; Byrne, 1997; Crisp, 2000), reduced social proximity with a person with a diagnosis (Reda, 1996; Jorm, 1999; Crisp, 2000), or the negative portrayal of this client group by the media (Link et al, 2001; Byrne, 1998a; Reda, 1993).

### **1.11 Aims of the present study**

The findings of these studies, although compelling, call for additional research to understand the contextual environments in which stigmatising opinions originate, and how they may change over time. Government documentation and policy supports this further, with a recent Department of Health publication on public attitudes on mental health/illness implying that greater understanding at this level may be a necessary step if change is to occur (DoH, 1999). Similarly, the National Service Framework for Mental Health published in 1999 suggests a need for mental health promotion, including raising community tolerance and social inclusion, and promoting mental health literacy in the general public.

Further investigation into the origins of such opinions within the general public will undoubtedly have a strong bearing on health promotion and educational campaigns to target stigmatisation. If previous authors' suggestions are correct, such research may also have implications for stricter control in the media of cinema, television and print.

No exploratory research into the origins of attitudes towards mental health has been carried out to date, suggesting both a need for research in this area, and the adoption of a methodology suited to generating rather than quantifying hypotheses. The researcher aimed to use Grounded Theory methodology (Glaser & Strauss, 1967) to explore members of the public's experiences of attitudes about mental health/illness

further. Such methodology is suited to research areas where theory relating to the topic is absent or incomplete (Henwood & Pidgeon, 1992). The present study aimed to identify the meaning and importance placed on perceived influences of attitudes by participants, and provide a forum to reflect on their development over time.

Within this, the study also aimed to examine the influence of the family on attitude development by interviewing members of the same family one generation apart. Further discussion of Grounded Theory as a methodology and the procedure followed in this study will be presented in the methodological review.

### **Research Question**

**What are members of the general public's experiences of people with a diagnosis of mental illness and how do they conceptualise the influences on their developing belief system?**

## 2. Method

### **2.1 Overview of Chapter**

A consideration of the features and usage of qualitative research methods will be detailed. More specifically, the development of grounded theory as a qualitative methodology will be outlined taking into account the different influences in its development and its fundamental epistemological assumptions. Ways in which grounded theory has been criticised and has been adapted in response to this criticism will be highlighted. Finally, a detailed description of the design employed in this study, alongside a review of the researcher's epistemological position, assumptions about the data, and the steps taken within this research to ensure rigour wherever possible will be outlined.

### **2.2 Qualitative approaches**

The quantitative paradigm assumes a combination of the scientific method and empiricism (Henwood & Nicolson, 1995). As such, value is given to research whereby observation of the relationship between variables is impartial, value free and measurements can be considered reliable and valid, thereby producing the same results if repeated under similar conditions. Methods are assumed to be *deductive* rather than *inductive* and are aimed essentially at theory testing and verification. Some authors have suggested that although having a crucial role in the progression of science, relying exclusively on such methods stifles the generation and development of theory (Henwood and Pidgeon, 1992).

From the 1960's onwards, researchers in sociology, anthropology and psychology began to feel frustrated with their perceptions of quantitative methods constraining research and providing data which they regarded as not accurately reflecting the complexities of 'real life' people, events and circumstances (Manicas & Secord, 1983; Polkinghorne, 1984; Stiles, 1990). They began to doubt the nature of social science

relying on data which represented 'truth', instead hypothesising that the search for truth and objectivity was futile in a field concerned with social activities and socially constituted meanings (Henwood & Pidgeon, 1995). As a result, qualitative methods were adapted to capture meaning and experience rather than quantify outcomes or relationships. Research within psychology however, remained aligned predominantly to positivist methods until the early 90s (Henwood and Pidgeon, 1992) with some concerned that to lose the science from psychology would lose the status that it fought so hard to receive within the scientific community.

Quantitative and qualitative methods subscribe to contrasting epistemological positions (Lincoln & Guba, 1985). A comprehensive review by Madill, Jordan & Shirley (2000) explicates the complex interplay between epistemology and quality assurance, stressing the crucial relationship between the kind of data a method purports to gather, and the ways in which the success of this can be evaluated. Madill *et al* suggest that quantitative methods are more easily aligned with the positivist paradigm, in which the production of data is seen as representing the reality of truth. Methods such as this have traditionally relied on the replicability of findings and the notion of falsification. Epistemological constructivism (Henwood & Nicolson, 1995) supposes that lay and scientific knowledge of the world does not merely reflect the world as it exists but are produced or constructed by persons and within cultural, social and historical perspectives. This focus changes the nature of the data generated in qualitative research and underlines the role of subjectivity. As a result of this shift, features considered within the quantitative paradigm to enhance the quality of a study such as its reliability and validity are deconstructed with a different focus. Several authors have suggested alternative means for evaluating quality in qualitative research (Stiles, 1993; Yardley, 2000; Elliot, Fischer & Rennie, 1999). These suggestions are detailed more fully and considered in relation to the current research at a later point.

Qualitative research methods attempt to understand people's perceptions, experiences and actions, and the meaning that they place behind these (Elliot, 1995; Grafanaki, 1996). They may attempt this by use of verbal data gathered during interview, participant observation, focus groups or by the close examination of language usage (Bryman, 1992). Such methods involve an iterative process (Mason, 1996) and are therefore fluid and subject to researcher choice throughout (Polkinghorne, 1991).

Many authors have stressed the importance of not viewing these two distinct approaches as being in opposition to one another. Qualitative and quantitative methods can be used effectively in the same research project (McGrath & Johnson, 2003; Todd, 1998) and to enhance the rigour of each by engaging critically with the other (Barbour, 1999). In their 1967 book 'the Discovery of Grounded Theory' Glaser and Strauss made clear that grounded theory was a general methodology applicable to both qualitative and quantitative studies and remarked that 'in many instances, both forms of data are necessary' (Glaser and Strauss, 1967, p18). However, different practical concerns and epistemological debates of what underpins research have led to a separation of these methods. On an epistemological level, their distinctive differences in the role of the researcher and the nature of knowledge development produce conceptual contradictions in terms of evaluating rigour.

Within the realms of qualitative research there are many distinct strands. These include methods such as Discourse Analysis (Potter & Wetherell, 1987), Conversation Analysis (Atkinson & Heritage, 1984) and Grounded Theory (Glaser & Straus, 1967). The history, development, epistemological and theoretical underpinnings of Grounded Theory shall be discussed in more detail, as this methodology was the focus of the present study.

## 2.3 Grounded Theory

### *History*

Grounded Theory methods emerged from the collaborative works of Barney Glaser and Anselm Strauss in the 1960's (1965, 1967, 1968: Strauss and Glaser, 1970) and arose from their desire to move from data to theory so that new theories could emerge. The methods outlined are suitable for studying individual processes, interpersonal relations and the reciprocal effects between individuals and larger social processes (Charmaz, 1995).

Grounded Theory works on the assumption that theory evolves during actual research, and it does this through the mechanism of continuous interplay between analysis and data collection. This two way process, termed 'flip flop' (Bulmer, 1979; Henwood & Pidgeon, 1992), characterises the dynamic core of this methodology, and underlines the creative and interpretive role of the researcher. Henwood & Pidgeon (2003) term this 'emergent design'. Grounded theory researchers are interested in patterns of action and discovering process, in terms of reciprocal changes in patterns of action. Whilst emphasising the theoretical aspects of social research, grounded theory therefore pushes its practitioners towards theoretical interpretations, making it a powerful and useful tool in clinical settings.

### *Methodological features specific to Grounded Theory*

Grounded theory involves the progressive identification and assimilation of categories of meaning from data using systematic inductive guidelines (Charmaz, 2001). It consists of a number of key components (Charmaz, 2001; Glaser 1992; Glaser and Strauss, 1967);

- 1) *The creation of analytic codes and categories developed from the data rather than from preconceived hypotheses*
- 2) *Simultaneous stages of data collection and analysis*
- 3) *Sampling on the basis of developing the emerging theory*
- 4) *The development of theory to explain process*
- 5) *Making comparisons between data and data and concept and concept*
- 6) *Keeping memos to explicate and fill out categories*
- 7) *Delaying of the literature review*

Key features also essential to producing grounded theory of a high standard are the *constant comparative method* and *theoretical sampling*.

### *Constant Comparative Method*

Advocated as a means of generating theory, the simultaneous involvement in data collection and analysis phases of research method employs the use of continuous sifting and comparison of data, emerging theory and cases throughout the research process in order to remain sensitised to similarities and differences in the text generated. It is anticipated that the use of the constant comparative method (Glaser & Strauss, 1967) will encourage theoretical development by enabling the researcher to continually divide categories into further elements of meaning so that the full complexity of the data can be acknowledged.

### *Theoretical Sampling*

This is a process of collecting data on the basis that it will challenge or elaborate existing emerging theory. After an initial selection of participants, the data is coded and analysed so that the researcher may produce a provisional theoretical explanation of the data. The researcher can then deliberately seek 'outliers' - people he or she expects may provide a contrasting account - thereby enabling the unearthing of the exception to further develop the theory. That is, that maintaining the weight of diverse perspectives may provide the researcher with a 'fuller' picture rather than a more 'objective' one (Fielding & Fielding, 1986). The purpose of deviant case analysis is not to challenge the emerging theory in the same sense as the notion of falsification in quantitative research. Rather, it provides an opportunity for the researcher to explicate the properties of categories further, by questioning the reasons behind the variation in the data (Mays & Pope, 1995; Barbour, 2001).

### *Reflexivity*

Potter (1996) commented on the researcher's inevitable position as a participant rather than an observer in qualitative research. Reflexivity therefore, refers to the to the researchers ability to be aware of the influence of their own construction of meaning on the research process and how this may impact on the subject matter. Similarly, by having an awareness of the influence of the socio-cultural frameworks that all participants exist within. The concept of reflexivity is not specific to grounded theory methodology *per se* but is regarded as a necessary part of all qualitative analysis. In producing qualitative research of a high standard it is therefore necessary to 'explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research' (Nightingale & Cromby, 1999: 228).

Willig (2001) identifies two types of reflexivity. The first is *personal reflexivity* 'involving reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research'. The second is *epistemological reflexivity* which asks 'how has the design of the study and the method of analysis constructed the data and the findings?' (Willig,

2001: 10). These issues are of vital importance to the research and will be returned to at a later point.

### *Criticisms of Grounded Theory as an approach*

Some authors have raised concerns about the use of qualitative methods at the expense of empirical evidence due to their 'rejection and devaluing of the scientific method, in favour of politically acceptable interpretations of discursive material' (Archer, 2004: 132). Others have raised its limitations as a method, both in terms of its alleged epistemological position, and warnings against improper use of its basic features. These issues will be discussed in turn. Other criticisms, such as the suggestion that grounded theory lacks features usually associated with 'scientific' research such as reliability and validity, and ways in which these are addressed will be discussed at a later stage alongside ways to enhance the quality and rigour of the present study.

The perspective claimed by Glaser and Strauss's original (1967) description of grounded theory methodology contained what Henwood & Pidgeon (2003) termed an 'epistemological tension'. That is, to suggest that theory emerges from the data assumes an alignment with scientific process and realism and suggests an external reality, unaltered by the presence of the observer (Charmaz, 1990). In short, they do not acknowledge the social construction of data (Hall, 2001). This conceptualisation then left the precise role of researcher interpretations in theory generation largely unexplicated and the approach open to criticism by those that were evaluating it using 'typical' scientific benchmarks such as reliability and validity. Over the recent decades this more positivist epistemology has been questioned and a social constructionist version of the approach has been suggested (Charmaz, 1990). From this standpoint, grounded theory does not capture reality but is in itself a social construction of reality. Pidgeon and Henwood (1997) suggest the term 'theory generation' as opposed to 'discovery' to highlight the constructive and interpretive role of the researcher in this process.

Other criticisms of grounded theory concern the potential risk of improper usage. Some have suggested that commitment to analytic categories before they reach saturation (Emerson, 1983; Katz, 1983) prevents the researcher from reaching ‘intimate familiarity’ with the meaning within the data (Lofland & Lofland, 1983). Others suggest that a lack of clarity of the key terms used in the approach and a tendency to use ‘unnecessary jargon’ may cloud the process (Charmaz, 1990). Furthermore Stern (1994) warns against ‘muddling methods’ and compromising the integrity of the approach. She suggests this may occur by providing detailed narratives of transcripts without ever reaching a conceptualisation of the processes inherent within participant’s accounts. Finally, as qualitative research does not necessarily seek to corroborate or refute prior findings, there may be a risk of duplicating theory using alternate terminology (Morse, 2000), rather than critically evaluating the findings in relation to previous literature.

#### *Applicability of the methodology to clinical psychology and the research question*

Qualitative research is concerned with meaning. That is, its focus is on how people make sense of the world and experience events. This is closely linked with the case conceptualisation or formulation element of clinical psychology in which therapists attempt to understand a person’s world based on their interpretation of it.

Grounded theory has been used to develop thinking in social psychology (Annesley & Coyle, 1998; Marsiglio, Hutchinson & Cohan, 2000) and clinical psychology (Borrill & Iljon-Foreman, 1996; Tweed & Salter, 2000). More specifically, and in relation to this study, the investigation of experience of families where a member has a diagnosis of mental illness (Rose et al, 2002).

## 2.4 Interviewing as a data gathering method

The semi-structured interview is the most frequently adopted means of data gathering in qualitative research due to the assumption that participants' viewpoints are more likely to be expressed in a relatively open designed interview situation than in a standardised interview or questionnaire (for example Kohli, 1978). It is suited to qualitative enquiry as it seeks to understand the meaning of phenomena from the interviewee's perspective and therefore their 'life-world' (Kvale, 1983). Similarly it is suited to epistemological standpoints such as social constructionism as it supposes that although interview responses are conceptualised as evidence of what people think, feel and perceive, such interactions are also considered to be temporally and contextually dependent.

Interview data has the capacity to be analysed in a number of ways producing a method of data collection that is compatible with different forms of data analysis. For example, this analysis can be focused on identifying what people *mean* when they talk, as in Grounded Theory, or by attempting to understand what people *do* with talk, as in methods such as Conversational Analysis (Psathas, 1995).

The use of semi-structured interviews is common in grounded theory methodology but it is not without its limitations. As with any interaction, an interview is a social situation in which personal dynamics may influence the outcome. There are inevitably inequalities regarding the perceived power distribution between the researcher and the interviewee (Oakley, 1981) which must be taken into consideration when forming conclusions about data generated. Similarly, it is important to recognise that despite grounded theory's emphasis on entering the research without *a priori* assumptions the reality is that the researcher has with him or her a list of research questions or topic areas to cover takes the interview away from the idealised non-directive position. In order to counteract the possible bias induced by this, the concept of reflexivity provides a forum to encourage a constant critical awareness of how such phenomena is influencing the emerging theory.

## 2.5 Present Study

### *Participants*

The present study involved interviewing 7 members of the general public about their attitudes towards mental health, and their ideas about how these have developed or changed over time. Table 1 presents some key information about participants based on the demographics sheet they filled in prior to the interview. Participants were all family dyads and are grouped accordingly in the table. Gurdeep was the only exception to this as his son chose not to take part in the study.

Dyad and family position	Current Age	Age at leaving full time education	Profession	Country of origin
Moirra (mother)	55	21	Property manager/teacher	UK
Jason (son)	28	23	Investment	UK
Sue (mother)	50	21	Deputy Headteacher	UK
Lisa (daughter)	22	22	Drama student	UK
Ann (mother)	78	15	Housewife	UK
Emma (daughter)	39	16	Assistant buyer	UK
Gurdeep (father)	65	32	Architect	India

**Table 1- Breakdown of participant information.**

The benefits of interviewing dyads a generation apart were hoped to be threefold. Firstly, it was hoped that this method would uncover links between patterns of opinion about mental health across generations. Similarly, it was hoped that the use of dyads would help to gain multi-dimensional perspectives on the formation and maintenance of attitudinal beliefs within the same family system, alongside adding to the existing knowledge about the transmission of attitudinal beliefs from parents to children.

### *Researcher*

The researcher was a final year trainee psychologist. She had previously been involved in research only of a quantitative nature, but chose a research question that warranted the use of qualitative methodology. After further consideration, she felt that the resulting methodology suited her beliefs about 'knowledge' and presented an opportunity to become skilled in a different mode of enquiry. The impact of this process on the researcher will be discussed in a later section.

### *Researcher's Epistemological position*

The researcher felt most aligned with a social constructionist epistemological position. This stance assumes that there is no distinct reality from which theory can be 'discovered' as implicated by Glaser and Strauss (1967) in their original description of the approach. Instead, social constructionism points out that 'human experience is mediated historically, culturally and linguistically' and therefore 'what we perceive and experience is never a direct reflection of environmental conditions but must be understood as a specific reading of that environment' (Willig, 2001: 7). As such the social constructionist version of Grounded Theory advocated by Charmaz (1990,1995) will be followed most closely in the analysis of data. In this strand of the approach it is not assumed that categories are discovered within the data, but rather that they are constructed between the researcher and the participants during the research process.

### *Researcher's assumptions*

The researcher was aware of being frequently surprised at the lack of knowledge and frequency of inaccurate references to mental illness both in the media and within the general public. Professional influence such as studying psychology at undergraduate level, working as an assistant psychologist and completing clinical training had all contributed to a sense of 'losing track' of how people without that specific educational and professional background view mental health/ill health, and in a sense,

how they come to form those opinions. Also, the researcher had an interest in family narratives - especially concerning 'stories' about mental health which in her experience are often loaded with messages concerning cause, prognosis and predicted behaviour. The researcher had provisionally searched the literature and discovered a gap in knowledge in investigations into which factors contribute to the stigmatising opinions of mental illness that have found to be so widespread in UK society (Crisp, 2000).

### *Research Design*

The study utilised a grounded theory methodology within a qualitative framework. This appeared to be the most appropriate method of enquiry given the research question outlined in the Introduction section. Interview transcripts were used as the main data for the study and analysed using combinatory variations of the approaches detailed by Charmaz (1995) and Henwood and Pidgeon (1996). Measures taken to address some of the criticisms of the approach will be addressed in the later part of the procedure section.

### *Procedure*

Outlined below is a detailed description of the research incorporating the recruitment of interviewees, method of data collection, the process of transcription and analysis, and how this analysis developed into conceptualisation. This section will also include references from the literature recommending best practice of analysis and ways to enhance quality in a research project of this type.

### *Recruitment*

Ethical approval was sought from the University of Leicester ethics committee and Leicester Partnership NHS Trust and granted on the 10<sup>th</sup> May 2003 and 13 August 2003 respectively. After this date the first dyad of participants were recruited via the researcher by being asked if they wanted to be interviewed for a study investigating

‘How families talk to each other about mental health’. The participant information sheet can be found in Appendix One.

Dyads were initially recruited opportunistically, as they were perceived to be likely to provide rich quality data (Marshall & Rossman, 1999). This form of non probabilistic sampling is not intended to find a representative sample from the population but rather to ‘identify specific groups of people who either possess characteristics or live in circumstances relevant to the social phenomenon being studied’ (Mays & Pope, 1995; 110). As the criteria for the study included most members of the general population (being part of a family system), a supplementary list of criteria, that of Morse (1994), was used to refine this catchment group further. Morse’s criteria for a ‘good informant’ are that they should have the necessary knowledge and experience of the issue at their disposal, that they should have the capability to reflect and articulate on the matter of interest, and that they should have time to participate in the study.

As the theory began to emerge, participants were sampled on the basis of its development. This theoretical sampling began after the first two dyads and led to choosing participants from an older generation who had not spent as much time in higher education. Lastly, the researcher chose to interview a father and son from a different cultural background to the other participants. Charmaz (2001, 2003) recommends allowing sufficient time before beginning theoretical sampling for significant themes to emerge.

### *Interview Guide*

A semi-structured interview guide was developed from discussions within supervision sessions and the researcher’s own curiosity surrounding topics which, to date, had fairly limited investigation. It also included questions to ‘test out’ speculations previous authors had hypothesised as being of importance. These were knowledge about mental health, proximity to somebody with a diagnosis and the influence of the media. The guide was intended to be a format to loosely base the interviews on but to derive data that was truly grounded the researcher was keen to follow the participants

lead rather than to constrain their answers or prevent them from initiating new topics. The interview guide was based on the following areas:

- Family background and structure
- Current understanding of the term 'mental illness'
- Contact with someone with a diagnosis
- Influence of the media
- Parents attitudes
- Recollections of family experience from childhood

Although the researcher's thought process had in some way been primed by an initial review of the literature alluding to the possible importance of the above topics, throughout the interviews all efforts were made to follow the participants lead on subject areas. The constant comparative feature of grounded theory incorporating simultaneous data collection and analysis led to the interview questions being modified somewhat as the researcher progressed through the interviews. Questions added included those pertaining to professional experience (e.g. 'How has your job changed or added to your views about mental health?'), as this seemed to be a factor which held importance for the participants. Modifying the interview structure in this way enables the researcher to follow theoretical leads (Charmaz, 1995).

### *Interview Procedure*

Most interviews took place in either the home of the participant or the home of the researcher. On arrival, the participants were again reminded of the aim of the interview and were asked to read and sign a consent form detailing their rights to withdraw and issues of confidentiality and anonymity (see Appendix Two). Gale (1993) highlights that although it is vital to obtain informed consent, participants will only have full knowledge of what the interview involves after they have experienced it. For this reason participants were informed that they could withdraw from the study at any time, including after the interview had ended. The participants were asked to complete an anonymous demographics form and information on the estimated length of the interview was given (45 minutes to 1 hour). Once it was clear that the

participants both understood the process and still felt comfortable to take part the tape recording began.

After it was felt that all the topic areas had been covered the interview was ended. Participants were asked how they had found the interview and thanked for their involvement. The researcher then made an entry into her research diary reflecting on her initial thoughts and feelings about the interview. These often included 'hunches' about what would later come out in analysis, or speculation as to how questions could have been asked differently to communicate meaning more effectively. The influence of the researcher in guiding the interview schedule was considered here also, in terms of how lines of enquiry may have been picked up and followed to the exclusion of other, perhaps more fruitful ones. Finally, after each interview an entry was made into the researcher's field diary detailing initial thoughts and reflections. An example of this is presented in Figure 1.

*16<sup>th</sup> November- Reflections on interview two-Jason*

*Was a bit shorter than the first but many of the same issues came up (family coping strategies, use of humour etc). Wonder whether Jason's interview was shorter than Moira's because he was younger and had less experience to draw on or whether it was something to do with the questions not having the same meaning for him. Jason seems to have very considered views and is particularly intelligent, it may be helpful to sample someone without the same levels of education next. Can already see some themes emerging which look particularly interesting. Reassuring!*

**Figure 1- Exerpt from researcher's field diary**

*Transcription of Verbal Data*

The tape recordings of interviews were transcribed verbatim by the researcher. All identifying statements were modified and participants were given a pseudonym to protect anonymity. The data was transcribed according to Strauss and Corbin's (1990) guidelines. Pauses that were felt to be significant (more than three seconds) were included as were verbal hesitations such as 'erm' as the author felt that these were significant of the weight given by participants unknowingly to the proceeding speech.

Generally features such as these are not included within data transcription in this methodology. Willig (2001) reflects that in grounded theory analysis we are 'only interested in the content of the interview' and that therefore we 'do not need to transcribe non linguistic features of speech'. The researcher deviated from this slightly in transcripts as it was felt that they assisted in giving the data more meaning. Charmaz (2003) recently suggested the benefits of noting these incidences of word finding difficulties and hypothesising why the interviewee may be struggling with articulation. The transcripts are not included in this thesis but are part of an alternate addendum which can be requested from the Department of Clinical Psychology via the course secretary.

## 2.6 Analysis

The researcher was influenced predominately by the analytic techniques suggested by Charmaz (1995), although aspects of Henwood & Pidgeon's (1996) version were also adopted. This procedure includes the following components: *line by line and focused coding; memo writing and conceptualisation*. A description of each will follow.

### *Coding*

In grounded theory codes emerge from studying the data rather than applying pre-conceived codes to the data as in some methods of quantitative analysis. By interacting with the transcripts, the researcher develops ideas about what the data are all about by 'defining the actions or events that are occurring in it or are represented by it' (Charmaz, 1995). In this way the process of line by line coding and focused coding serve to create categories which build theory from the ground up (Charmaz, 1990).

### *Line by line coding*

Initially, the researcher utilised a line by line method of coding to analyse the data, with the intention of remaining true to its content. Charmaz (1990) describes the

purpose of this as being a means to ‘build up the analysis from the ground up without taking off on theoretical flights of fancy.’ In this respect, Glaser’s (1978) concept of ideas ‘earning their way’ into the analysis begins to take shape. Line by line analysis forces the researcher to conceptualise the material in new ways and gain sufficient distance from the data to begin to understand what the interviewee is expressing rather than applying their own assumptions onto the data. As a consequence of this process the researcher creates a large number of initial codes describing the data based on a detailed analysis of each segment. An example of a page of transcript coded in this way can be found in Appendix Three.

### *Focused coding*

Focused coding is more directed than line by line coding and involves taking codes that continually reappear and using them to sift through the rest of the data. In this way the researcher is making an analytical decision about which aspects of the data interest them most and are most likely to answer the research question in a way that can inform clinical practice. It is therefore considerably more selective and more conceptual (Charmaz, 1983; Glaser, 1978) and leads to the creation of categories which conceptualise the data.

### *Memos*

Memo writing was used as a means to document the researcher’s thought process as data collection and analysis progressed, therefore, as a key feature of the constant comparative method. It aided the processes of conceptualisation and theoretical sampling, and the thought processes behind the emerging theory more explicit. Memos are used to take categories apart and define them into components (Charmaz, 1995). The memos, developed in conjunction with coding of individual interviews were regularly reviewed as part of the iterative process of developing the substantive theory. An example of a memo made by the researcher can be found in Figure 2.

*MEMO-Transcript 2, p9, line 265*

*Jason talks of feeling 'less compassion'. How is compassion mediated? Which factors contribute to feeling compassion for somebody? Inherent in this statement seems to be an attribution of blame although this is not made explicit. Ask about this in further interviews.*

**Figure 2- An example of a memo taken from the researcher's field diary**

### *Conceptualisation*

By means of the constant comparative method, categories which occurred repeatedly in transcripts, themes which appeared to hold particular resonance or processes which were of particular interest to the researcher were examined in detail. The researcher drew diagrammatic models after each interview to represent the message she felt was within the participant's account. These diagrammatic models were initially fairly disparate, but through theoretical sampling, adjustment of the interview schedule and constant comparison a 'storyline' (Strauss & Corbin, 1990) began to emerge which the researcher felt represented key features of the accounts. Through rigorous documentation, memo making and defining and redefining the properties of each category a model was developed which represented an amalgamation and conceptualisation of the data. This model contained a core category and six main categories and is detailed in the Analysis section.

### *Theoretical saturation*

While the earlier stages of Grounded Theory require maximum openness and flexibility to identify a wide range of predominantly descriptive categories, theoretical sampling is concerned with the refinement and ultimately, the *saturation* of existing categories (Willig, 2001). Theoretical saturation is often conceptualised as an aspiration rather than a practical likelihood and Glaser and Strauss (1967) remind readers that 'theory is always provisional'. However, Rennie, Phillips and Quartaro (1988) suggest that saturation may begin to occur after 5-10 cases.

## *Deviant Case Analysis*

After having identified categories or theory to describe the process emerging from the data, the researcher looks to find instances of cases that 'don't fit'. That is, which challenge the researcher's assumptions and ensure that he or she continues to develop the emerging theory in the light of the evidence and not on the basis of 'homogenising impulses' (Willig, 2001).

## **2.7 Issues concerning rigour**

### *Reliability and Validity*

Historically, reliability refers to the degree in which procedures generate similar findings when reproduced. As mentioned previously, it is recognised that qualitative methods cannot be judged by the same criteria applied to quantitative methods due to their contrasting epistemological standpoints (Henwood & Pidgeon, 1992). In the case of the grounded theory interview, it is perhaps impossible to recreate the account due the complex interaction of personal dynamics between the interviewee and researcher, although data similar in content could be generated. Furthermore, Kvale (1983) has argued that 'the qualitative interview can change participants by getting them to think about issues or recount narratives, during which the events and feelings get reconstructed' (In Memon & Bull, 1999: 96). This would suggest that the mere procedure of doing an interview changes both the researcher and the researched. Hammersley (1992) defines validity as 'the extent to which an account accurately represents the social phenomena to which it refers'. Again, in a scientific positivist paradigm this may be interpreted as the extent to which the measure assesses what it alleges to assess. Some authors such as Agar (1986) reject this notion altogether on the basis that there is no objective reality to be measured. Ways to ensure alternate criteria for assessing grounded theory methodology such as 'plausibility and credibility' have been suggested (Hammersley, 1992). Methodological tools employed in the present study to enhance quality in grounded theory research based on the above criticisms are detailed overleaf.

### *Methods used to enhance quality in the present study*

Several authors have attempted to produce guidelines outlining standards of good practice within qualitative research, each grounded in a variety of epistemological positions (Elliot et al, 1999; Henwood and Pidgeon, 1992; Stiles, 1993; Yardley, 2000). As the most recent version, Yardley's suggestions for encouraging quality in qualitative research are presented as ways in which the researcher aspired to ensure rigour in the present study. Yardley suggested three main criteria covering three areas.

The first of these is '*sensitivity to context*'. This can be established by being considerate of the literature both in relation to the concept under investigation and the methodology being adopted for the purpose of the study. Also, this sensitivity can be evidenced by the use of quotes from the participants' accounts to ground the data. Finally, sensitivity to context involves the researcher considering the relationship between the researcher and participant, and ultimately the wider socio-cultural milieu in which this exists. In this way, sensitivity to context reflects the wider notion of reflexivity mentioned previously.

The researcher used a field diary to record thoughts about process at each stage. Reflections before and after interviews, alongside observations and beliefs about the emerging theory were noted and provided a tangible prompt for reflexivity. These themes were also discussed within a qualitative research group consisting of peers in the same stage of the research process and the research supervisor. Supervision was also used as a means of reflection, adding to what Stiles (1993) and Hoshmand (1994) have speculated is a forum for decreasing researcher bias, offering new perspectives and providing affirmation.

The second proposed criterion is that of '*commitment, rigour, transparency and coherence*'. This contains an assumption of 'immersion' within the data, facilitated by the transcription and studying of participants' accounts, and a commitment to the rigorous application of the method to this data. Furthermore, researchers can add to this quality by being explicit about the research process and stating their epistemological position. This criterion can be evidenced by the detailed description

of analytical procedure and the documentation of every stage of the decision making and conceptualisation in a field diary. The researcher used diagrammatical representations of her thought processes during every stage of the research process which demonstrate how the model developed over time. Similarly, all decision making and moments of insight were documented in a field diary. These document the researcher's thought processes over time, adding to transparency and demonstrating commitment to the process.

Lastly, the principle of '*impact and importance*' suggests that the research provides the reader with an appreciation of its applicability in the clinical arena or existing knowledge base about the chosen topic. This feature is concerned with whether the theory generated may have an impact on clinical practice, social policy or may lead to further research of such importance. These issues are considered within the Discussion section.

A further step taken to ensure rigour in this study was that of multiple coding. One method to enhance rigour in qualitative research can be the degree of consistency that concepts are assigned the same label by different observers, or by the same observer on different occasions (Hammersley, 1992). This concerns the cross-checking of coding strategies and interpretation of data by independent researchers. In practice, this usually involves having another person review sections of data or emerging coding frameworks. This has been compared by some authors to the qualitative interpretation of 'inter-rater reliability' in the quantitative sphere (Armstrong et al, 1997; Barbour, 2001). Debates surrounding this have focused on the amount of variation in the way researchers 'package' coding frameworks even though there is considerable consensus in codes allocated by researchers (Armstrong et al, 1997). A consensus of agreement between researchers is not considered vital, rather, that any conflicting explanations can be explored further and used in the process of refining codes and categories to produce a thorough and insightful interpretation of data. In the present study, a monthly qualitative research group provided a forum for multiple coding and allowed the researcher to gain alternate perspectives on transcripts alongside mutual support and peer supervision.

### *Against the 'ensuring quality' framework*

Barbour (2001) warns that the use of checklists to ensure quality in qualitative research does not, in itself ensure rigour. Historically, authors such as Feyerabend (1975, 1978) have argued against the use of stringent methods to enhance quality in research stating that the limits inherent in any form of methodology can only be tested by research that violates it. He supports the argument therefore that 'scientific progress has resulted not from allegiance to methodological rules but from breaking them' (Salmon, 2003: 25). The suggestion that research which adheres to methodological rules limits scientific progress is perhaps one which is more sound in ideological rather than practical terms (Rennie, 2000; Robinson, 2000).

A presentation of the data and the way in which the researcher interacted with it based on the assumptions of this methodology and a social constructionist epistemological stance will be detailed in the next chapter.

### 3. Analysis

#### **3.1 Overview of Chapter**

This chapter provides an account of the analysis of the seven transcripts as a result of the implementation of methods described in the previous chapter. The researcher's understanding of the transcripts is presented by a model comprising of one core category and six main categories. This model is presented graphically in Figure 3. The core category and each main category will be discussed in turn, including a detailed description of the categories' properties and characteristics. Excerpts of transcripts are used to illustrate each concept and are presented in indented paragraphs using italicised text. Each quote is followed by a reference to its location in the transcripts by the participant's pseudonym and the line number referring to its exact place in the text. Discussion of how each of the categories interact with one another and how negative cases were taken into account, plus wider reflections on the influence of interviewing dyads will be considered.

The model depicts a process of developing a personal and fluid understanding about mental health. It is based on the interviewee's descriptions of their life history alongside individual speculations on the formation of their attitudes and implicit messages bound up in the text. It is constantly under revision and informs how a person may view an individual suffering from psychological distress. It consists of a core category and six main categories.

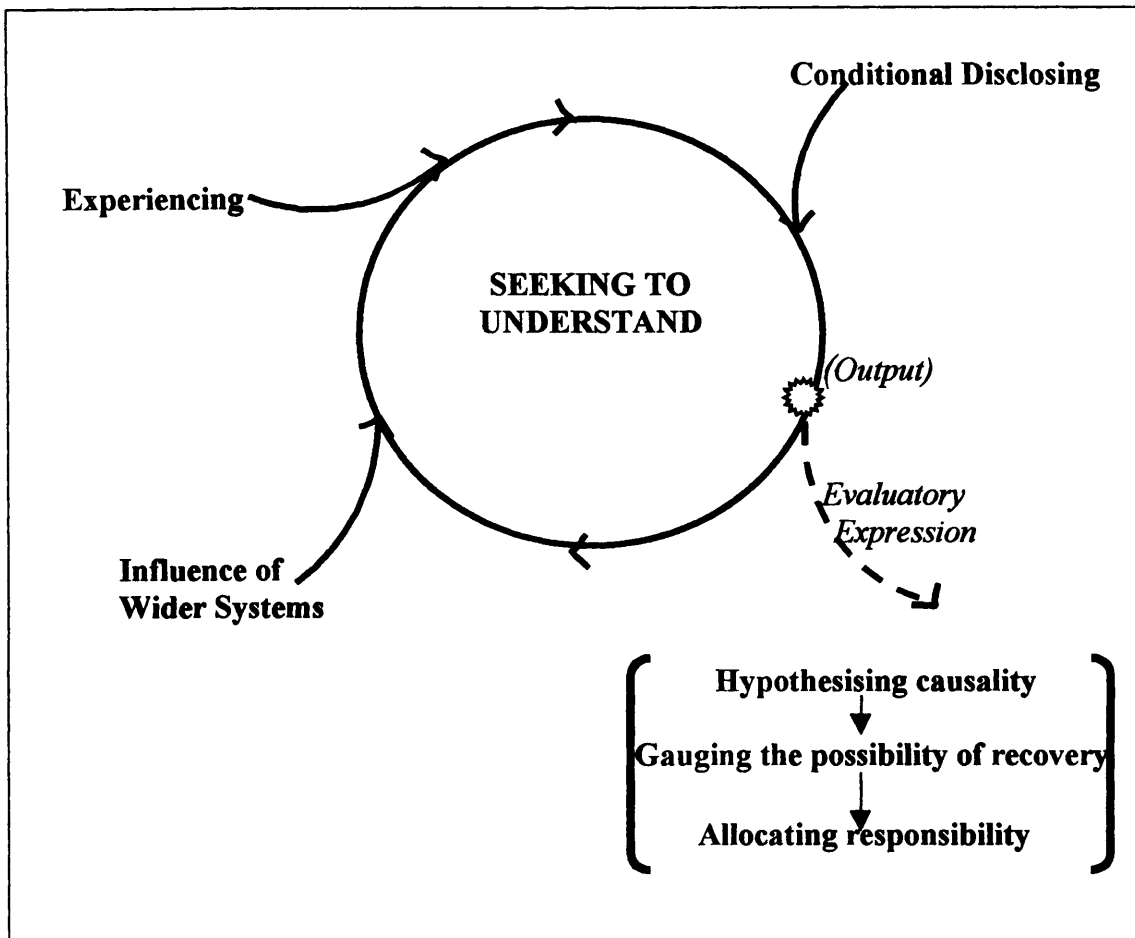


Fig 3-Process Model – ‘Seeking to Understand’

The core category is termed ‘*Seeking to understand*’ and although an abstract conceptualisation, still remains grounded in participant’s accounts. It represents a constant process of comparison, revision and reflection driven by uncertainty and the basic human desire to ‘make sense’ of the world. In doing this, the individual draws on three main constructs; messages implicit in ‘*conditional disclosing*’ about mental health both in society and within their family system, ‘*experiencing*’ and the way people have made sense of this, and drawing on the ‘*influence of wider systems*’ such as culture. In this way, each of these processes impinge upon the other and create a fluid and reflective concept of individual understanding.

A further three main categories are represented in the model and shown to be a product of a process named '*evaluatory expression*'. This process can be seen to represent a 'snapshot' of the circular process at any one time and is a result of the researcher and participants' interaction during the interview. This is a consequence of the fluidity of the model and the constant overlaying of information derived from different sources. The 'output', which in this case was the product of the interview, can be viewed as being akin to turning a tap which spills out a liquid, giving understanding to what is inside the container. The process is noted on the diagram and consists of three main categories; '*hypothesising causality*', '*gauging the possibility of recovery*' and '*allocating responsibility*'. The core category and each of these main categories shall be discussed in turn, with demonstrative excerpts of text from participants to clarify each category.

### 3.2 Core Category - Seeking to Understand

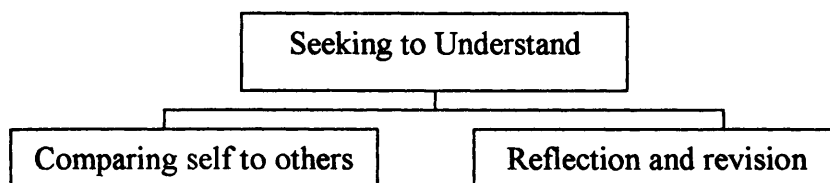


Fig 4- '*Seeking to Understand*'

This category is represented in the model by an unbroken circle and is characterised by the uncertainty that was present in the transcripts around aspects of mental health. Displayed by all participants by hypothesising and reflection, this process can be conceptualised as similar to a vacuum, whereby people seek to fill the void with the available materials they have to hand. Participants are constantly drawing on sources to seek to understand experiences, in this case mental health/illness.

By means of this process, individuals create an understanding under constant revision, as they are confronted with ideas challenging their beliefs, people who contradict stereotypes they once held, or material which sheds light on something they once

knew nothing about. For these reasons this process is displayed as a circle which is never static and has no start or end point. As can be seen from Figure 4, it has two subcategories '*comparing self to others*' and '*reflection and revision*'. The circle is constantly being added to by the three main categories feeding into it.

#### *Subcategory - Comparing attitudes to others*

When asked about their family and peers, most interviewees had ideas about how their views about mental health compared with those of people that they come into contact with, or, society as a whole (see '*influence of wider systems*'). Views about mental health were seen as predictable in the sense that if views were shared generally they were likely to be shared in this arena. This concept was also characterised by speculation that sharing experiences, or sharing personality traits would lead to similar attitudes about mental health. Emma and Jason commented on this phenomenon;

*'I don't think I share the same views as my mum I really don't on most things actually! Not just mental health although on mental health may be we do actually cross over on views more than other things because I know my mums suffered herself. Maybe that means her outlook would be similar to mine...'*

(Emma: 209-213)

*I'd probably say that my views are quite similar to my mum's in a lot of ways but we haven't really discussed it and I guess from a personality perspective I'd say we are probably quite similar.*

(Jason: 136-139)

### *Subcategory - Reflection and revision*

The fluidity of attitudes is mirrored by the participants accounts of their revision over time which can be guided in different ways. Firstly, some participants recounted powerful examples of attitude revision based on instances when their attitudes were confronted with contradictory evidence. This kind of experience produced dissonance and was resolved by revision and an acceptance of an alternate understanding. This revision sometimes took the form of a fairly drastic change of tack, as in the case of Emma, who talks of how her experience of post natal depression changed her outlook completely;

*'I always thought it was something that if a person was depressed it was something that was in their mind, you know people weren't strong enough to cope, and I think I'm quite a strong person and If I couldn't cope then it is obviously an illness. Whereas I never thought it was before see.'*

(Emma: 14-18)

In other cases this attitude revision was seen as a more gradual process, involving the continual incorporation of life experiences, such as education, professional encounters and the messages implicit in the subject of mental health. This is described by Sue in her account as she speculates on how her attitudes have changed over time;

*'Well with regard to my attitudes I think possibly inevitably they've changed as I've grown up because as a child I remember it was a subject that was quite taboo certainly in my family but obviously with education and the job that I do now inevitably I've got a much broader view of the subject.'*

(Sue: 13-17)

Whereas Sue hypothesised that her opinions had 'broadened' over time, Lisa speculated that subjects such as mental health become more complex with age.

*'...when you're younger things are more black or white and you'll look at someone as being crazy or... not [laughs]. Whereas now you're more aware of the social issues and you hear more and more about mental illness all the time in the media and coming to understand more about it and it's causes and what you know there's lots of social issues surrounding it. So I think that more... you know, greater awareness of it as a whole, so you know that things are not so black and white there's lots of grey areas.'*

(Lisa: 199-206)

This increased complexity may be due to the fact that influences on attitude taken on board by the individual are not necessarily congruent with one another and may be held together despite seeming confused or conflictual.

### **3.3 Main Category - Conditional Disclosing**

This main category consists of two sub categories 'choosing the audience' and 'choosing a storytelling style' which each contain several key concepts. It is represented graphically in Figure 5. '*Conditional disclosing*' refers to the decisions made about talking about mental illness and the way in which individuals tell stories in a way that feels 'safe' and unthreatening. All participants referred to the style in which their families and significant others in their life did this. Conditional disclosing contains implicit assumptions about mental health which feed into understanding through learning. For example, this may be as a result of childhood experiences of overhearing adults speaking in 'hushed tones' about a family member experiencing psychological distress.

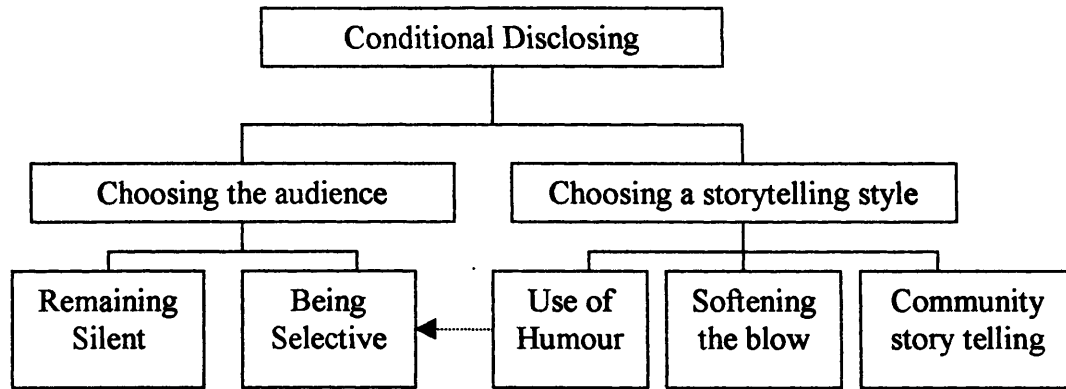


Fig 5 'Conditional Disclosing'

*Subcategory - 'Choosing the audience'*

Throughout the interviews, participants made reference to the fact that mental health issues were not, or should not, be discussed openly within the family, and especially in front of children. This could be because the topic is seen as too provocative, too difficult to grasp or too shameful to be shared openly with vulnerable others. In her account, Sue reflects on an experience of this;

*Sue: '...and depression was very much... well it was never mentioned it was never talked about. But yet I know that my mum had a couple of close friend who were 'on those tablets' which I think might have been valium or something which looking back although I couldn't be sure... it was under the carpet because it was a sign of weakness wasn't it?*

*Researcher; It wasn't really talked about?*

*Sue; Yes, and when it was it was talked about very quietly and I was never included in those conversations.'*

(Sue: 163-171)

### *Remaining Silent*

Several of the participants talked of the importance of not talking about issues related to mental health, either in terms of disclosing their own difficulties or as a trend within their own family system.

*'But I wouldn't tell people that I'm depressed because it depresses other people when you say it. I'd never tell the kids I just find something to do to take my mind off it in the house.'*

(Ann: 42-44)

In many ways this category was influenced by the openness of dialogue within the family to begin with, as dyads revealed trends about how they communicate generally, and what is and is not acceptable to bring up. This trend shall be discussed more fully in the reflection of the use of dyads at a later point.

### *Potential negative case example*

Initially it appeared that an excerpt from Moira's account contrasted with this theme quite significantly;

*'I just went every month with my mother to visit. It was just like a special day out to the country which was, you know, a long bus ride you know we'd be away sort of like... well we'd be away all day from early morning to go and spend this two or three hours with her. But I never saw it as anyone and people would say when we got back, 'oh, you know, how is Ginny?' Like other aunts and people who knew her. It was never swept under the carpet it was never tried to hide.'*

(Moira: 419-425)

This appears to be a negative case example. Moira presents this aunt and her life in the institution in an exceptionally positive way. This is covered in more detail in *'softening the blow'* as a feature of the next subcategory. It could be hypothesised that this presentation and the subsequent concern of friends and relatives serves as a message to the listener that the exclusion of the family member from society should not be interpreted as a signal of a lack of compassion on behalf of the family. It is also possible that there are further 'rules' under the category of conditional disclosing which have not been highlighted yet due to this category not reaching saturation. This shall be addressed further in the discussion.

### *Being Selective*

This concept of 'choosing the audience' does not just relate to family members.

*'...it wasn't until I'd been taking antidepressants for at least a year before I talked to anyone about it and I think once I'd told people... the people I did tell were very very good about it it was only close people to me but they said, 'why didn't you tell us before?' But I didn't feel like I could, had to keep it to myself and I think it was thing that because I thought that people would think what I did, I think that was why I didn't tell anybody.'*

(Emma: 43-49)

In this excerpt, Emma describes choosing to disclose the difficulties she was experiencing to people that she considered 'safe' to tell, as she feared that they would hold the same negative opinions as she once did prior to her own experience. Eventually she found disclosing to be a positive experience, but she frames it in terms of a risk that she took time before taking. She goes on to speculate that conditional disclosing may be responsible for a society where psychological distress is common but unrecognisable in others;

*'I didn't realise its so common but then when you think about it you don't go round saying, 'Hi I'm Emma and I've got depression.' It's not one of the things you would say so you wouldn't know who did and who didn't. '*

(Emma: 234-237)

### *Subcategory - Choosing a storytelling style*

When stories about mental health were told, participants recalled their telling in a particular fashion, which created a category named '*choosing a storytelling style*'. This subcategory contains three concepts; the '*use of humour*', '*softening the blow*' and '*community storytelling*'. A link is made between the concepts of use of humour and being selective. This is explored further below.

#### *Use of humour*

The disclosure or discussion of issues relating to mental health appear to be made less difficult by framing the interaction within humour. Four of the participants talked of using humour in this way.

*'I'm sure they probably mentioned mad old aunts like auntie Martha I'm sure mum always said she was a bit nuts! I'm sure but just in kind of a jokey way, 'ahh your mad old auntie Martha...' yeah.'*

(Lisa: 188-190)

*Researcher: '...and was it something that was talked about quite openly as a family or did you not really discuss it that much?'*

*Jason: 'Not really I don't think... and certainly not in a serious type matter erm the only time it would be discussed would be more in a light hearted matter where tales had been told, and it sounds bad to say entertaining but erm you know there were some quite funny tales about my uncle going off having his episodes and sitting with Beelzebub next to him in the police station, so tales like that were told in a more light hearted manner and that's probably you know people that are close to the situation its always easier to deal with something by laughing about it rather than getting too uptight about it.'*

(Jason: 111-121)

Jason alludes to feeling some guilt in the way he and his family use humour in reference to his uncle ('sounds bad to say entertaining') but it appears to be a very effective way of being transparent about a subject that he recalls no open discussion about. He also speculates about the usefulness of this storytelling style as a family coping mechanism. Also within this concept is the assumption of implicit understanding as in the account of Moira when speculating on what her sons made of her use of humour when talking about her brother Steven;

*Researcher; I wanted to ask you do you remember how you talked to them about Steven at the time when they were younger?*

*Moira; Erm... quite derogatory if I'm honest really! Erm, I think we've always... I don't know I think you'll have to talk to them but I think we've joked about it you know uncle Steven is on a different wavelength you know but I hope they haven't taken it as erm... I hope they know when I have said things in a jokey way really I hope they don't think I'm seriously knocking mental illness. I would hate that.*

(Moira; 482-489)

In Figure 5 ‘conditional disclosing’ a dotted arrow is drawn from use of humour to being selective, to highlight the importance of judging who this storytelling style can be used with. This is illustrated in the account of Moira, who recalled being particularly upset after watching the film ‘One flew over the cuckoo’s nest’;

*‘I can remember driving home from the cinema in the car crying. And I’ve got a vivid memory of that journey and it was obviously linked to what I’d seen in the film and linking it to Steven and thinking, ‘I don’t want this for him. I don’t want him to be mentally ill. I don’t want him to be like this. I want him to be normal’. And I don’t think I’d ever cried about it before. That’s the only time because I think always... we tried to get around it in a jokey way I think. You know we’d... as a family I think we tried to cope with it with humour but I was by myself- or with someone who didn’t know anything about Steven- and so I couldn’t joke about it.’*

(Moira: 533-542)

It is also worth noting that several participants also used humour within the interviews to recount stories which could be considered especially difficult to talk about. This further supports this method of storytelling as a process which enables a subject area that feels difficult seem less threatening. An example of this can be found in the transcript of Sue (p.7, line 202-204).

### *Softening the blow*

Jason and Moira both made reference to family members who had mental health difficulties in an exceptionally positive way which did not seem to ‘sit right’ within the rest of the text. Initially coded as ‘painting an idyllic picture’ the function of this method of storytelling was considered via the use of memos and hypothesised to serve the function of being a ‘positive reframe’. This reframe negates the perceived stigma

attached to mental health difficulties or the potential negative aspects of being institutionalised as in these two cases.

Jason refers to uncle who received a diagnosis of schizophrenia. He mentions his uncle's brilliance several times during his telling of the story, alerting the researcher to the fact that this element of his uncle's presentation is especially significant to him.

*'he'd been some accountant - quite a whiz or something - and erm it was may be portrayed to me may be as that the pressure became too much and he'd had a some kind of breakdown...'*

(Jason:90-92)

*'But then in my uncle's case I guess it was erm... I think he was quite an intense worker and erm and apparently very brilliant and maybe just the ability to cope I don't know but maybe the ability to cope with the outside world erm flipped him out I don't know.'*

(Jason: 187-190)

It could be hypothesised that presenting his uncle in this way 'softens the blow' of his experience of psychosis, which may be seen by Jason as an essentially negative part of his character. Similarly, Moira remembers visits to a family member who spent her life in a psychiatric institution and hold a particularly positive opinion of what life was like there;

*'...auntie Ginny has this softening of the brain and we'd go and visit in this beautiful hospital out in the country and we'd see her where there's a lot of other people who have this, and we'd go like once a month to visit her and it was er... they'd have like, beautiful big theatres and halls, and they'd all dance but they were all a bit simple minded people really.'*

(Moira: 391-396)

It is hypothesised that this way of perceiving Ginny's life may serve to avoid a consideration of the negative aspects of institutionalisation and therefore any negative emotions associated with this. However, as this concept only arose out of the transcripts of two participants, these hypotheses remain in need of further consideration.

### *Community storytelling*

This concept refers to the ways in which society creates a narrative around mental health and uses community storytelling to open up a dialogue to convey news or an event. Most participants used terms like 'nervous breakdown', 'nutcases', 'crackers' and 'psycho' to illustrate ways in which people in their community were talked about, or ways in which they had referred to family members who had mental health difficulties.

*'My aunt had a nervous breakdown but erm they just said she's crackers!'*

(Ann: 107)

It is difficult to know what purpose this terminology serves for the individual and the community but it may be that it serves a variety of functions. Having a lack of understanding about mental health issues may lead to a limited dialogue meaning that slang terminology with confused meaning is substituted instead. Most of the participants used the term 'nervous breakdown' at some point in their transcripts often to describe very different presentations. Diagnostic labels were also used but not necessarily in a way that they may be used by professionals. Terms like 'crackers' may overlap with use of humour as a way to make a difficult subject easier to talk about. Finally, using terms which imply mental illness pejoratively may be present in a society which still holds stigmatising opinions about mental distress.

### 3.4 Main Category - Influence of Wider Systems

This category comprises of influences outside of the individual and the family system which may have an important role in the developing understanding about mental health. It is broadly split into two subcategories which are '*media presentations*' and '*societal standards of normality*'. Concepts discussed in relation to these subcategories are *linking media to personal experience*, *informing knowledge*, and *awareness of stigma*. The influence of politics, religion and culture were mentioned to a minor extent by some participants but are left out of the analysis. This omission is due to the lack of focus on these factors by the researcher and shall be discussed at more length in the Discussion section.

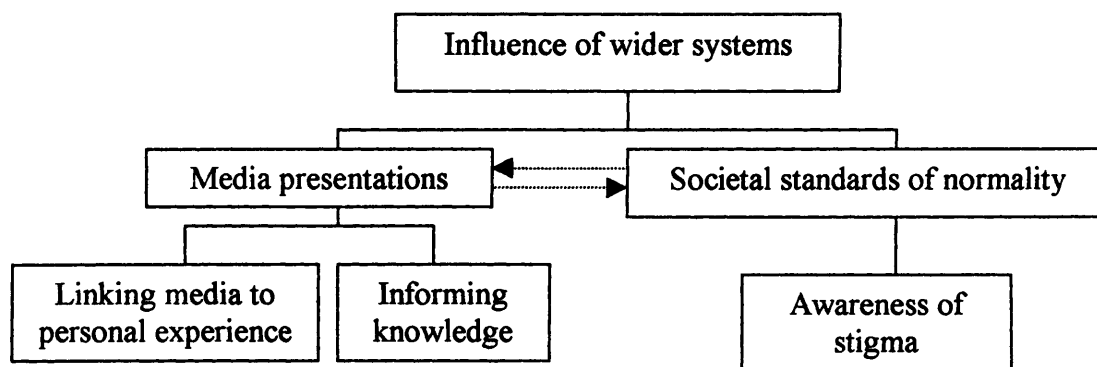


Fig 6- 'Influence of wider systems'

#### *Subcategory - Media presentations*

Jason speculates on how the media, as part of the influence of wider systems, merges with factors involved in the core category, '*seeking to understand*'.

*'The images in your mind are probably coming from media stuff. My understanding, you know, it probably triggers a thought process and you think about it in your own mind and that I guess then moulds or shapes all of these triggers. You start thinking about what your views are on certain aspects, but other than the beautiful mind film I don't know if I can think of any other films*

*that I've seen but you know, there's probably comments in these other TV shows and comedy shows talking about nutcases or whatever so it probably just in fact it probably helps to maintain the stigma against mental illness.'*

(Jason: 304-313)

Also generated within the interviews were views of the informative value of film, television and literature, ideas about whether to 'trust' the media's message or not and consideration of how the media can link with personal experience. Each of these factors shall be considered in turn.

#### *Linking media to personal experience*

*'I've read about schizophrenia trying to understand Steven and films like 'One flew over the cuckoo's nest' you know when I saw that when it came out years ago it really really upset me I can remember crying and crying thinking erm that it was horrible. And because I thought...linked it to personal experience and didn't like it at all.'*

(Moir: 522-527)

Film and television were often related to personal experience by the participants and appeared to hold particular resonance if they contained themes similar to ones the participants had direct experience of, either in their own mental distress or that of a family member.

### *Informing knowledge*

The media was also framed as an educational tool, with participants accepting its presentation of certain diagnostic phenomenon as fact;

*'I think Hannibal Lector is a fascinating character really he's just so intelligent you know, so that probably in a way has you know possibly indirectly made me think you know, that not all mental people are stupid you know they're not all thick they're not all can't function.'*

(Lisa: 88-92)

Alongside its use to broaden knowledge, some participants highlighted their scepticism towards the media and rejected the media's message, suspecting it to be sensationalised or inaccurate;

*'I tend to take what I read in the paper anyway with a pinch of salt I mean the headline will always be something like 'mad man' or something like that 'psycho' and I think certain papers deal with it better than others...'*

(Lisa: 111-114)

### *Subcategory - Societal standards of normality*

Literature cited previously highlighted the concept of normality as a cultural phenomenon. For example, in African countries psychosis may be celebrated as a spiritual gift and diseases such as pneumonia may be stigmatised. Interestingly, Moira recognised the concept of normality as being innately flawed (Moira, p2, line 45). Nonetheless most participants commented on what appeared to be a shared cultural understanding of what is considered to be 'normal' and markers that can be used to assess this in others in others.

*'I think certainly from seeing my uncle you can control it with drugs but then, you know, he's not normal he's never going to be normal his life is somewhat restricted...'*

(Jason: 170-172)

Societal concepts of normality also included expectations about roles people should be able to perform in society, such as having a family, maintaining employment and being able to function within social situations.

*'I think it's a marker that we can use. If someone can function at a level where they're holding down a job they're in a better situation than someone who can function just within society but not really working.'*

(Moir: 31-34)

Jason alluded to the fact that it may not necessarily be the state of a person's mental health that leads to their exclusion from society through institutionalisation, but the extent to which their behaviour is causing distress to those around them;

*'...if somebody's just going along living a normal life not bothering anybody not bothering themselves then they can probably be nutty as a fruit loaf without erm anybody coming to be aware of it you know but if it's running down the street with no clothes on ...shouting about Beelzebub being next to them then erm that may be becomes more of an issue.'*

(Jason: 50-56)

Failure to adhere to these societal standards may result in that person being treated differently, either in the exclusion of that person from a particular group or from society as a whole.

*Lisa: 'I'm sure people did treat him differently maybe just as someone who's a bit weird I'm sure they did.'*

*Researcher; 'What do you think they did to treat him differently?'*

*Lisa: 'Avoided him and... but I must say as the weeks went on and they got to know him he's just like one of the group now it's great.'*

(Lisa: 254-258)

### *Awareness of stigma*

This concept refers to the extent to which the participants recognised that there was stigma about mental illness present in society.

*'there is stigma in society people don't want someone with a mental illness living next door to them.'*

(Moir: 369-370)

Almost all of the participants talked of the stigma present in society in relation to mental health. Interestingly, all of them refuted that they held stigmatising opinions, and often gave examples of instances where they, or somebody that they knew, came into contact with a person with a diagnosis and did not act in a way indicative of such opinions.

After further consideration and questioning, it appeared that the stigma recognised in society as a collective is rejected if the individual is known to the person making the judgement. That is, a person on the street may be considered to be 'a bit mad' and to be avoided, but a person who has other concepts attributed to them in the form of a friend or a family member is not stigmatised in the same way.

*'I think people in general who've never suffered they'd probably criticise someone who someone like Frank Bruno but I just feel for him basically and I think that the ignorance of it, it does put*

*stigma on people especially someone in the public eye rather than somebody we know somebody we work with but you wouldn't criticise them as much.'*

(Emma: 159-164)

### *Potential Negative Case*

The importance of knowing the person on the influence of stigmatising beliefs was quoted by several participants, either directly or indirectly (Sue: line 249-251; Emma: line103-104; Moira: line 297; Lisa: 235-237; Gurdeep line 189-191). However, when questioned further, Jason refuted this hypothesis, stating that he felt this was more to do with his personality;

*'I think its me as a person rather than knowing somebody. I mean, I think even if I didn't know somebody within the family, I think the way I am I would try not to be judgmental about anybody or anybody's life or beliefs and I think that's just my make up.'*

(Jason: 317-320)

Whether this is the case, or whether it could be argued that individuals would not necessarily have insight into their own motivations to hold stigmatising opinions, or be consciously aware of the contributing factors in the development of their personality over time requires further investigation.

### 3.5 Main Category - Experiencing

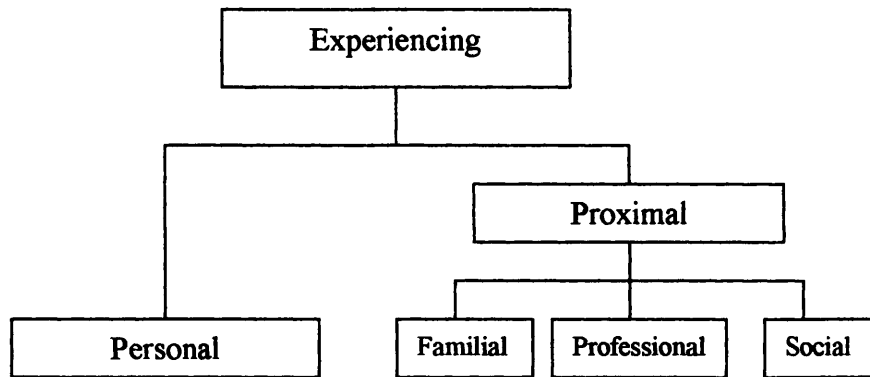


Fig 7- 'Experiencing'

This category details what appears to be an important learning tool in the formation of opinions about mental health. Participants drew on past experiences to illustrate their beliefs and made links between what they had seen and their opinions.

All participants except Gurdeep talked of knowing somebody who had or was experiencing mental distress (including self). This experience seemed important in the hypothesising present in the latter half of the diagram (when thinking about causality, gauging the possibility of recovery and allocating responsibility) as it provided participants with a clear framework from which to base their opinions. Gurdeep was a potential negative case as he was the only participant to have difficulty in answering questions about causality and the recovery process. Perhaps one of the reasons for this was that he did not have any direct personal experience to draw on.

*'So I suppose from being a very young girl I had that contact, so I suppose the seeds of mental illness were put then. That there's nothing wrong with these people, these people are... its... well there is something wrong with them in the fact they can't function in society...'*

(Moir: 396-400)

*'But unless you have some connection, either family or friend it's probably something that you don't give a lot of thought to- it just kind of exists erm whereas, if there is like, I'm saying you've been affected by it in any way you probably think about it more or are more aware of it.'*

(Jason: 83-86)

Participants were more likely to talk about psychological disorders that they had some experience of. Ann and Emma talked of depression, Moira and Jason talked of schizophrenia and Sue and Lisa talked of developmental disorders plus schizophrenia. Gurdeep didn't mention any diagnostic category. It is possible that it is easier to express an opinion on conditions that they have had direct experience of or heard of frequently.

Moira remembered an incident from her childhood experience for the first time during her interview which may suggest that this aspect of understanding mental health is not necessarily part of conscious awareness. She felt that an aunt who had been institutionalised played a big part in her developing an understanding about mental health and how 'these people' were. This is not something she had given any thought to prior to the interview and in fact surprised herself that she had forgotten about this experience. This case highlights the fact that not all of these experiences are accessible to the person when asked but may be a feature of attitude formation nonetheless.

*'Now I'd forgotten about that yes I suppose I always Steven as my first big exposure to mental illness but I suppose it wasn't it was Ginny, my aunt.'*

(Moira: 412-414)

*'I don't think you consciously think about it but perhaps you've got this deep down perhaps it goes right back to Ginny and me as the 8 year old child linking this 50 year old woman thinking, 'she's my friend, she's my playmate' you know, you don't know what's going on do you?*

(Moir: 675-679)

### *Sub Category - Personal*

Both Ann and Emma talked of their experiences of suffering from depression and how this had impacted on the beliefs they held about it.

*Researcher: 'And do you think that your attitudes towards things like depression have changed since experiencing it yourself?'*

*Emma: 'Definitely yes I always thought it was something that if a person was depressed it was something that was in their mind you know people weren't strong enough to cope, and I think I'm quite a strong person and If I couldn't cope then it is obviously an illness whereas I never thought it was before see.'*

*Researcher: 'I see'*

*Emma: 'I thought it was just an excuse to be honest but it's totally changed my attitude.'*

(Emma: 12-21)

*'I think there are a lot of people depressed and it would affect the nerves so badly. It's affected me badly. I can't sleep at the minute with the things that are going on in Iraq. It's affecting us all badly. I worry about the children badly. It has affected me, it's depressed me quite a lot.'*

(Ann: 18-22)

Although Ann is not explicit in how her personal experience of depression has affected her view of it, implicit in the text is a message that it is both common, and as a result of psychological factors. She continues with this hypothesis of causality throughout the text when discussing other forms of psychological stress.

### *Intermediate category - Proximal*

All of the participants except Gurdeep recounted an example of somebody they had come into contact with either at work, within the family or by another means (friend/neighbour) who they believed to be suffering from mental health difficulties. These experiences also contributed to understanding.

### *Sub category -Familial*

Sue, Moira and Jason had experience of witnessing a family member suffer from mental health difficulties.

*'...my mum went through a funny time as well when she retired so that was when I was older, and I saw a great change in her and she became depressed erm and she just wasn't the person that I'd known, she changed completely, started drinking...'*

(Sue: 171-174)

Alongside this contributing to understanding, other factors were involved in this experience, such as the coping mechanisms the family adopted and the emotional reaction to this change in circumstances. These factors were not considered to be of relevance to this particular model but were noted by the researcher. They shall be discussed further in the next chapter.

### *Subcategory - Professional*

*'...I've had, children who have refused to speak in the classroom so we've talked about that as being a medical problem... erm I've had a child who I can't remember what the diagnosis was but who had, he tried to, erm he used to run off on the road and he used to throw himself down he tried to commit suicide a few times and erm... we talked as a main class about how we could help him.'*

(Moir: 643-649)

*'...in many ways you feel helpless as I don't feel qualified but to comment or to offer advice but you find yourself in that position...'*

(Sue: 39-40)

Coming across mental health issues as a professional was mentioned in two of the transcripts (Moir and Sue). It is worth noting that although this was not an area of intense investigation and focus, participants with jobs likely to involve such issues also build on their experience this way. Sue and Moir were both primary school teachers and frequently came into contact with children or parents that they had concerns about. There were also issues of feeling helpless, being unqualified to help and of feeling unprepared for these situations by their formal training.

### *Subcategory - Social*

Other instances of knowing a person with a diagnosis were quoted by participants.

*'To be honest I've not really had much contact at all although at ballet school there were quite a few girls with eating disorders erm so in that case yes erm but not really.'*

(Lisa: 41-43)

*'Our neighbour used to be - well he probably still is - schizophrenic and although we never had any problems with him he did suffer a few years ago, and erm, the likes of eating disorders yeah they're mental illness and I've got a friend who was anorexic actually and I mean she's actually fine now I mean she's come out of it the other side but she did suffer quite bad.'*

(Emma: 103-108)

In a similar way to the other two subcategories, this experience is incorporated into the process of 'seeking to understand'.

### 3.6 Process - Evaluatory Expression

As highlighted by Figure 3, this process represents a 'snapshot' of the circle '*seeking to understand*' at any one time. In this instance, it can be seen as a product of the interaction of the researcher and participant. As can be seen from Figure 8, the main categories produced by this interaction are; '*hypothesising causality*', '*gauging the possibility of recovery*', and '*allocating responsibility*'. Each of these main categories aid the listeners' understanding of participants' experiences and influences regarding mental health to date, as the expression of attitudes in this way contains valuable messages regarding how they originated.

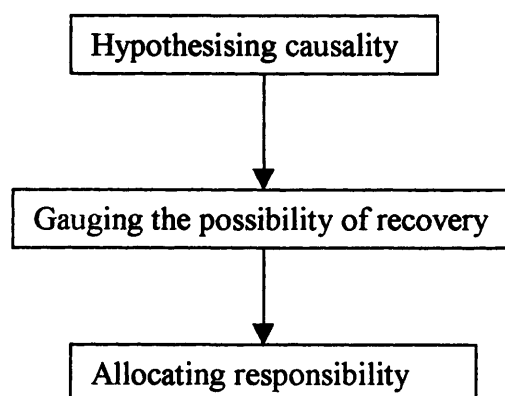
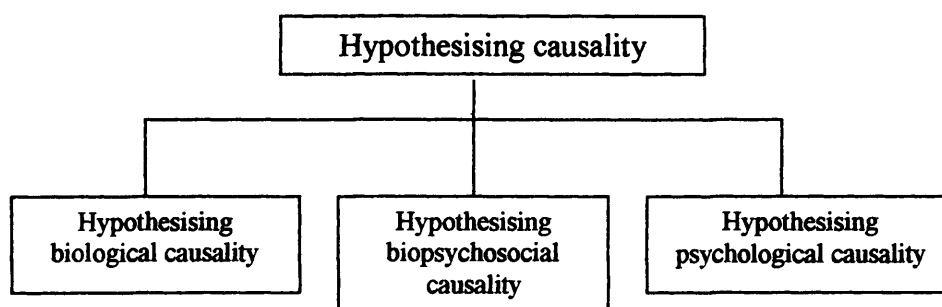


Fig 8- 'Evaluatory Expression'

It is this part of the model which may have direct clinical relevance in terms of how individuals may perceive and react to a family members' diagnosis. This clinical relevance will be addressed at a later stage.

### 3.7 Main Category - Hypothesising Causality



*Fig 9- 'Hypothesising Causality'*

*'you kind of think, how or why does that happen to somebody?'*

(Jason :103)

Hypothesising causality may be the initial evaluatory process occurring when an individual learns about somebody receiving a diagnosis. It is the bridge between expressing attitudes and making an evaluatory judgement about course, outcome, and the diagnosed's role in the course of their own mental health. In some ways it is the crucial factor in how an individual may react to the news that a member of their family is suffering from mental distress in terms of whether they perceive they will 'recover', what they believe the best treatment options to be for that person, and how much they believe the person has the ability to 'pull themselves together'. This category is based on the basic human desire to understand human experience and search for causality in events.

Hypothesising causality was a category that all participants speculated on at several points throughout the interview. This was either pertaining to somebody they once knew, such as a family member colleague or friend, a person in the public eye such as a celebrity, or a general opinion they held about the causality of a specific form of psychological distress (such as depression).

The attribution made was not necessarily a clear one and several of the participants frequently contradicted themselves within the text, citing two seemingly opposite views and voicing their confusion around this topic. An example of this can be found in two excerpts of text from Sue's transcript;

*'I mean it is chemical changes isn't it and unbalances and things that can cause all sorts of situations'*

(Sue: 268-270)

*'I know there must be reasons I think it stems from the fact that she lost a baby a few years ago and I don't think she ever quite recovered'*

(Sue: 329-331)

Other participants appeared more certain of the factors which may contribute to poor mental health and were consistent throughout the interview citing causality which appeared to be attributable to similar psychological or biological processes. An example of this can be found in the text of Ann, who attributed psychological triggers to a variety of mental health problems throughout her interview;

*'mental illness can be caused by stress as well you know, quite a lot of stress can be caused by... erm... it also causes Alzheimer's disease I'm sure, having too much on your mind you get yourself mixed up, doing too much as well that could cause Alzheimer's disease and that. Breakdowns. A lot of nerves, a lot of breakdowns.'*

(Ann: 7-11)

*'Well there was my auntie who was crackers. My uncle was carrying on and she had a breakdown.'*

(Ann:126-127)

These conclusions are based on the conceptualisation of attitudes that has gone before, in the circular process of the model. They are fluid, situational and person-dependent. This will be addressed in more detail at a later stage.

The consequences of this confusion about causality seem to be vast. Attributing difficulties solely to psychological causality (such as Alzheimer's disease) as in the case above may be just as unhelpful to the family member with a diagnosis as it would be to attribute certain difficulties solely to biological processes. This shall be discussed further at a later stage.

As can be seen from Figure 9, this main category contains three subcategories; hypothesising biological causality, hypothesising psychological causality and hypothesising biopsychosocial causality. These will each be addressed in turn.

#### *Subcategory - Hypothesising biological causality*

*'I would say that I see it as a physical illness a mental illness, I just see it as a disorder of the brain that you could have a disorder of..you know, your kidneys or whatever'*

(Moir:353-355)

*'I only found out by chance that my mum suffered from depression and I think she still does basically erm... and apparently its something that's hereditary'*

(Emma:233-234)

Some quotes from interviewees allude to the belief that biological processes are the causal factor for mental health difficulties. These processes include chemical imbalances in the brain, the influence of genetics and as a 'disorder' of the same type as a disorder of another part of the body. It is important to recognise that this trend of 'medicalising' mental health problems is stronger when participants are referring to certain types of difficulty specifically, such as schizophrenia. Although confused at points, these attributions may reflect scientific thinking and parallel opinions held by groups of professionals on this matter.

#### *Subcategory - Hypothesising psychological causality*

This subcategory concerns psychological factors that the interviewee perceives to be at the root of mental health difficulties. These contain concepts such as loss of role, stressful life events, trauma, effects of poverty, childhood experiences, and the responsibilities of parenthood. Some quotes relate to this directly, such as in the transcript of Jason when recounting the story of colleagues at his place of work;

*'at work there was erm a lady who had had erm its probably a depression type thing, in fact there were a few of them, erm a depression type related sickness and that seemed to stem from a hostile work environment in that they didn't get on with the people they were working with they were erm middle aged ladies erm yammering on at each other and having fights, and then one would go off for a few months with depression or whatever it is'*

(Jason: 251-257)

Other quotes have a psychological attribution implicit within them such as that of Sue, when in talking of her fears for her own children's mental health, suggests that it is their psychological robustness which will guard them against this. Coded as 'Protective factors', this concept would suggest that if mental illness can be protected

against then it is perhaps incongruent with the concept of 'illness', which is by scientific definition, out of a person's control and can affect all people without discrimination. Illnesses such as influenza for example, affect all parts of society, and cannot be guarded against by strength of character. The quote reads;

*Researcher; 'And have you ever had fears for their mental health?[daughters]*

*Sue; 'Erm, I think there have been instances and situations that have happened you know, break ups of relationships and things but they're both incredibly strong people and I don't think I would have any to be honest but you never know do you?'*

(Sue:264-268)

Some sections of the text underline the importance participants place on concepts such as loss, such as in the transcript of Sue when discussing her mother's period of depression;

*'And I think it was something to do with her retirement, you know she finished work and she felt 'what's the purpose? What use am I? My family live away..' and I think she could see that her days were just, you know, meaningless..'*

(Sue: 228-231)

#### *Subcategory - Hypothesising biopsychosocial causality*

As mentioned as part of the main category, frequently interviewee's attributions of causality relating to mental health problems included contradictory statements, including both psychological and biological attributions. The following quotes further support the uncertainty present in participants' conceptualisation of mental health, driving the process of *seeking to understand*.

*'I'm not 100% sure what I think on it. I guess there's depression, certainly I would say is some form of mental illness. I don't know enough about eating disorders to say if it's mental or physical or... I guess it's got to be mental but.. but certainly depression.'*

(Jason: 17-21)

More frequently however, was a conceptualisation of mental illness as being a combination of biopsychosocial factors. This was demonstrated in the transcripts of Lisa and Emma. However, the uncertainty in these texts is still obvious.

*'I think it can be.. I'm not really sure really. I think it can come from maybe... I'm not sure if it's genetic or not I think in some cases it.... I'm not sure but sometimes I've heard on the news that you know, there's different studies done and there's a certain gene which might trigger off certain types of behaviour. So I'm not sure if that has anything to do with it or sometimes someone has undergone acute distress or trauma then that might trigger off a reaction to that in the form of mental illness.'*

(Lisa: 29-36)

*'I think it could be yeah [to do with early experiences] I think so yeah but I'm not sure whether the imbalance bit comes from the lifestyle you lead or things you eat or whatever I don't know no idea.'*

(Emma: 57-59)

### 3.8 Main Category - Gauging the possibility of Recovery

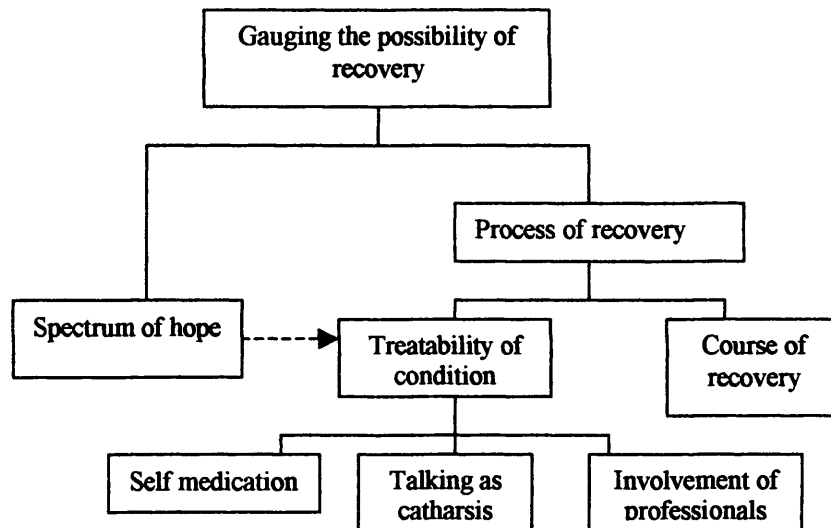


Fig 10- Gauging the possibility of Recovery

*'It's certainly controllable. Erm whether there's a cure or not I don't know. Hopefully there will be a cure at some stage but I think at the moment, I don't believe there is erm, hopefully they will in some future day and age find a cure erm, but I guess to do that they need to find out what causes it whether it's genes whether it's pressure, whether... I mean I don't know.'*

(Jason: 173-178)

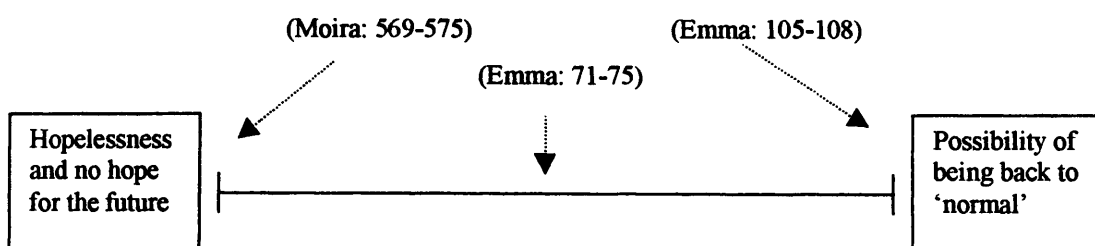
This main category follows on procedurally from 'hypothesising causality' as the process of judging the outcome of a given situation can be seen as dependant on the explanation for the cause of such a situation. Once a diagnosis of say, depression is judged to be attributable to the primary effects of transient relationship difficulties, an onlooker may deduce that recovery is hopeful and may have ideas about how long that may take, how it may be achieved, and whether recovery will be full or partial. Jason alludes to this process in his quote in which he talks of his uncle's mental health difficulties. He speaks of his hope for a cure in the future, which insinuates an all-or-nothing approach to treatment. This is in contrast to his earlier remark about his

uncle's problems being controllable. It could be speculated that an overall eradication of 'symptoms' is seen as superior to the control of those symptoms to a certain extent.

As can be seen in Figure 10, this main category 'gauging the possibility of recovery' contains the subcategory 'spectrum of hope' alongside an intermediate category named 'process of recovery'. This intermediate category is divided further into the sub categories 'course of recovery' and 'treatability of condition', the latter of which contains three key concepts; 'self-medication', 'talking as catharsis' and 'professional involvement'. A description of these key features together with ideas about how they interact with one another follows.

### *Subcategory - Spectrum of hope*

Within the texts there was a wide range of opinion concerning the possibility of recovery from mental illness, creating concepts of 'Hope' and 'Hopelessness'. Consequently, it seemed reasonable to conceptualise this subcategory as a spectrum, with hope for recovery and hopelessness as polar opposites. These different standpoints are best illustrated by Figure 11, a diagrammatic representation of 'spectrum of hope', plus the proposed positions of selected excerpts of text on the spectrum.



*Fig 11- Spectrum of Hope*

*'you can deal with physical illnesses, there is some hope of cures but I think one part of me I think with mental illness I've got this attitude of 'there isn't a cure'. Presumably because I saw Ginny as a child and she died in that state, she was no better. I've seen Steven for many years- over 30 years- with no cure or no change, so I suppose what I've got from family knowledge of mental illness is, erm there isn't a cure for it.'*

(Moir: 569-575)

*'Yeah, I mean it takes time to recover from it from where I'm sitting. I mean obviously I didn't have it... some people have really bad mental health don't they? Erm, I wasn't in that state and erm how long theirs takes I don't know. Probably a lot longer if they ever recover, and I do feel for those people to be honest.'*

(Emma: 71-75)

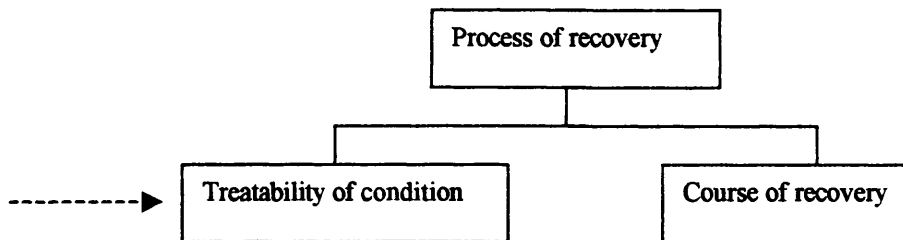
*'the likes of eating disorders yeah, they're mental illness and I've got a friend who was anorexic actually and I mean she's actually fine now I mean she's come out of it the other side but she did suffer quite bad.'*

(Emma: 105-108)

It is worth noting that the concept of a spectrum of hope is not a unitary one, that is, each participant may have varying ideas on outcome dependent on who they may be referring to and what kind of mental health problem they are making reference to. In cases such as Moira, it may not be viewed possible for a person to make a complete recovery. Others such as Emma, recount narratives of complete recovery alongside cautionary tales of those that there is a possibility 'cannot' be helped. As can be seen in Figure 10, this 'spectrum of hope' impacts directly onto the intermediate category

‘process of recovery’, and in particular, the subcategory ‘treatability of condition’. This will be discussed in further detail below.

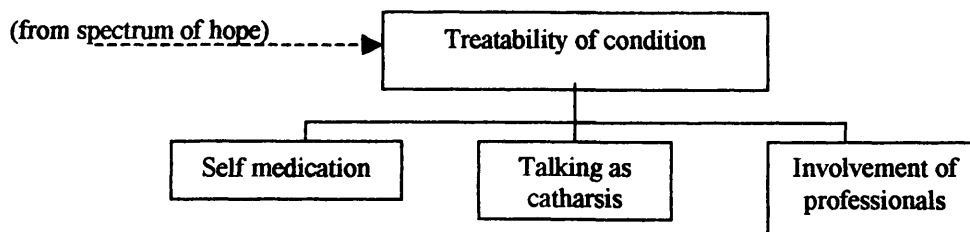
*Intermediate category – Process of recovery*



*Fig 12- 'Process of recovery'*

The intermediate category ‘process of recovery’ refers to a perception of a course of action undertaken by either the individual or professionals in order to relieve an individual of psychological distress. In this way it has both a start point and an end point and contains two main subcategories; the perceived course of the recovery process and the perceived treatability of the condition.

*Subcategory - Treatability of condition*



*Fig 13- 'Treatability of condition'*

Perceived treatability of a given condition can be related directly to the categories of attributing causality and the spectrum of hope mentioned previously. It is an amalgamation of two processes; how an individual perceives the said mental health difficulties to have arisen (i.e. genetics, life transitions, trauma), alongside their perceived hope or 'faith' in the recovery process. This latter process is illustrated on the model by the use of a dotted arrow. In her interview, Lisa considers this process and makes three main points: that there can be more than one method of treatment, that cases may vary in their presentation and therefore need for such treatment, and that there is a hypothesised causal link between severity of symptomatology and amount of time required to be treated.

*'I suppose maybe depression can be treated by counselling or certain drugs but perhaps for more extreme cases they may have to be detained in an institution and need longer periods of time to enable the patient or the person who was mentally ill to recover.'*

(Lisa: 22-26)

It is worth noting that Lisa was not alone in quoting 'longer periods of time' as a necessary feature and variable in the treatability of a condition. It seems that interviewees generally felt that time was an asset to enhance treatability.

Following on further from Lisa's quote, three main concepts arose from the transcripts relating to 'treatability of condition' as can be seen in Figure 13. These were: self-medication; talking as catharsis and involvement of professionals. It is worth noting that the weight given by participants to professional involvement in the form of detaining persons under the Mental Health Act or administering medication was far more than that given to self-medication or talking as catharsis. This is reflected in the number of quotes throughout the transcripts pertaining to this concept in relation to the others. For this reason, 'involvement of professionals' will be discussed first.

### *Involvement of Professionals*

*'I can't remember what the breaking point was, but it was something where they eventually thought, 'he needs help' and erm ...the GP was involved and then the specialists were brought in.'*

(Moir: 85-87)

Most of the interviewees referred to the involvement of professionals within their text, either in referring to help seeking behaviour or, more usually, in the prescription of medication.

Professional involvement was frequently spoken about in a patriarchal sense, with the utilisation of methods such as sectioning and enforcing treatment seen as a way in which society was making a judgement that a person required help, and was not capable to judge their own best interests. In his interview, Jason spoke of this process;

*'it's my perception that you know, under these type of conditions...[people] are potentially, you know, they're not able to look after themselves shall we say and therefore they're not...they need to be protected in some way by society.'*

(Jason: 64-67)

**Use of medication-** this was cited by all interviewees as the primary method of treating psychological distress. Views on this ranged from being positive, perceiving medication as a way to improve the person's quality of life, to implicitly negative, implying that medics were irresponsible with their prescribing rights, or that doctors were themselves not advocates for this method of treatment.

*'some people just keep on and on taking them and taking them [anti-depressants] and they get really addicted to them. I think it makes you very depressed in the long run and see instead of the doctor taking them off they keep prescribing them and they're worse.'*

(Ann: 34-37)

*'he was on Prozac just at the time I went to the school and they'd [the boys parents] fought this because they didn't want him on any drugs. His mother was a doctor and she tried very hard to keep him away from any drugs but eventually they gave in.'*

(Moir: 687-690)

Paradoxically, although it would seem that only in cases where distress is attributed to a biological causality medication would be the treatment of choice this did not come across in the text. Instead, pharmacology was cited as the only way to treat mental health difficulties by all interviewees except Ann and Emma who also gave some thought to 'talking as catharsis'.

Within the concept of involvement of professionals, 'non-compliance' with the treatment regime arose at several points in the transcripts. This can be defined as the person's desire not to follow the advice of professionals, or to show resistance to the prospect of being sectioned. Some interviewees experienced this first hand, such as Ann. Others, such as Sue, witnessed it first hand with family members.

*'The doctor said that she was going to have to be seen by a psychiatrist and it was so funny looking back because he said to her, 'Right. I think you're going to have to come with me,' and she said, 'I'm not going to any hospital! I'm not going to any nuthouse!'*

(Sue: 194-197)

**Talking as catharsis-** In her transcript, Emma also made reference to the benefits of talking to a trusted other who need not necessarily be a professional. In her case, she felt that the mutual support shared by her and a close friend with anorexia throughout her depression assisted them both in alleviating distress.

*'she used to sit and talk to me for hours you know, and I'd always be there for her and we'd sort of like talk to each other about our problems and I found it relieving that she could talk to me and I could talk to her and I think we got through a lot of it together.'*

(Emma: 13-16)

**Self-medication-** Use of alcohol and over the counter remedies are suggested as some of the ways in which people may attempt to self medicate. This could take one of two forms. Either in the form of a conscious decision not to take medical advice, or, as a strategy to cope with the emotional sequelae of a given condition.

*Moirra; 'I do know he was treated for alcoholism. But I don't think he was an alcoholic at all. I think it was the mental illness.'*

*Researcher; 'A symptom of..?'*

*Moirra; 'He was drinking. But I think it was the mental illness and I don't think he was ever an alcoholic.'*

(Moirra: 101-105)

### *Subcategory - Course of Recovery*

This category contains ideas relating to what form the recovery process will take and principally relates to the nature of certain manifestations of mental illness as enduring and involving the person experiencing relapses. This is demonstrated by text from the interviews with Moira and Sue as can be found below;

*'And since that first breakdown, I mean that was- the first breakdown was a mental breakdown really, but subsequent times he would...'*

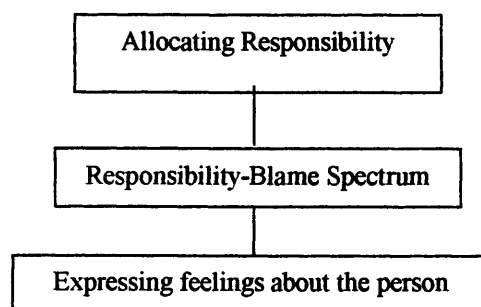
(Moira: 94-95)

*'..and to this day she... well, I was going to day she's never looked back but there was an episode a couple of years ago...'*

(Sue: 179-180)

Both participants make reference to their family members psychological distress as being something that re-occurred, albeit perhaps in a different form, at a later date. It should be noted, however, that these participants both share the experience of having an immediate family member receive a diagnosis, which is perhaps a key feature in their comprehensive understanding of the variable course of such distress over a given time period.

### **3.9 Main Category - Allocating Responsibility**



*Fig 14- 'Allocating responsibility'*

The main category of allocating responsibility could be seen to relate to the concept of 'ability to pull oneself together' as in Crisp's (2000) study. It concerns to what extent a person views that an individual with mental health difficulties has any degree of control over their distress. It can be a consequence of hypothesising causality, as it is negated by how much of a role the person is perceived to have had to play in the onset of their own difficulties and the course of their own mental health.

Attributing responsibility in this way may then lead to an emotional reaction, named 'expressing feelings about the person', which can range from compassion and sympathy to irritation and annoyance. This process is illustrated by Jason's feelings about colleagues that he knows to be suffering from depression;

*'...the stuff I've seen in work I tend to be less compassionate about because I think they, you know, they're doing a job that's stressful and they can't cope with that may be they're in the wrong industry and shouldn't be doing their job erm and to come in and be bitching at each other and essentially causing what ends up taking them off sick I don't sounds harsh but I don't have much compassion for...'*

(Jason: 264-270)

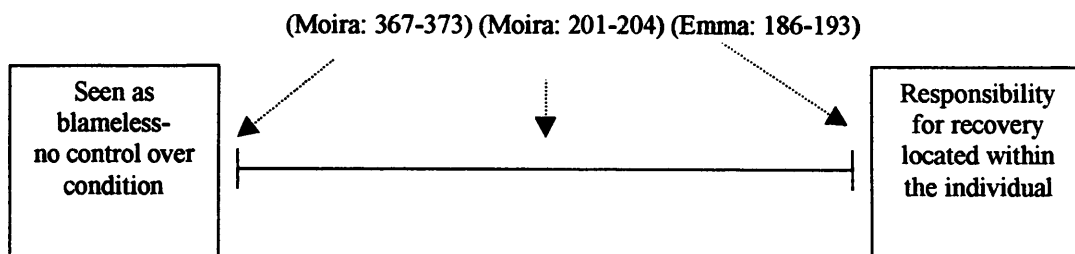
This category also follows 'gauging the possibility of recovery' as if a person is seen to have some agency over their own mental health it is perhaps expected that they should make more of an attempt to 'help themselves' than a person who is viewed to be at the mercy of genetics or biological factors. In addition to the subtext of this present in Jason's quote, reference is made to this by Ann when she talks of a relative of hers, sectioned under the Mental Health Act after suffering what she termed a 'nervous breakdown';

*'...and I said, 'You can't do this, you've got to pull yourself out of it.''*

(Ann: 144-145)

### *Subcategory - Responsibility-Blame Spectrum*

Throughout the transcripts it can be hypothesised that an individual makes a judgement about a person suffering from psychological distress based on their current understanding about its causes and whether there is a capacity to recover. At this point a decision is made pertaining to the allocation of blame. Outward awareness of this process may be limited, although all participants made reference to this in some form within their interview. Individuals are placed on a spectrum which ranges from being perceived as completely blameless, to the responsibility for symptomatology and recovery being located within the individual. This process is not necessarily related to an explicit dichotomy between the medical model and psychological influences. That is, it does not follow that a hypothesis of psychological causality leads to an expectation that a person is to blame for their own distress. This spectrum is presented diagrammatically below, alongside the proposed positions of selected excerpts of text to illustrate different points across the spectrum.



*Fig 15- 'Responsibility-Blame Spectrum'*

*'...you can't say its someone's own fault they've got a mental illness but I know there is stigma in society people don't want someone with a mental illness living next door to them .I know that exists but I don't know if they have that opinion because they think it's their own fault they're mentally ill, like if someone*

*was in a wheelchair would they say they don't want them living next door?'*

(Moir: 367-373)

*'...while one part of Michael would say he couldn't help it I think the other part would say he's selfish and we've got to stop everything were doing to see to him.'*

(Moir: 201-204)

*Emma: 'I think they've got more control being anorexic than being schizophrenic.'*

*Researcher; 'And do you think with that comes a sense that you should do more about it?'*

*Emma: 'Yeah I mean like my friend she came to work and she was very very thin and people would comment on her weight and she would say, 'look I know I'm thin but I can't help it, I can't make myself eat,' and I used to think, 'but if you know that why can't you make yourself do it?'*

(Emma: 186-193)

As highlighted by the comments of Emma above, it appears that participants may make a differentiation between the allocation of responsibility when considering different diagnoses. Emma also expressed her confusion regarding her friend's awareness of her difficulties and her reluctance to act on this information, possibly reflecting the role that insight may have in negating responsibility. Gurdeep also commented on the role of insight in a similar way (Gurdeep, lines 177-179).

As with the other categories, allocation of responsibility is mediated by understanding, based on personal experience and the other influences into the core category 'seeking to understand'. Emma gives a particularly good example of how her

opinions about blame changed drastically after experiencing depression herself (Emma: lines 14-21) This section of text supports the concepts of *hypothesising causality, comparing self to others, expressing feelings about the person, allocating responsibility*, and the *revision and reflection* component of the core category.

*Subcategory - Expressing feelings about the person*

*'I just feel sorry and pray for them'*

(Ann: 108)

Participants frequently expressed an emotional reaction to the process of allocation of blame, resulting in the creation of a subcategory '*expressing feelings about the person*'. These feeling ranged from sympathy and compassion, to annoyance and irritation and were mediated by whether they felt the individual had any hand in their current circumstances. Participants frequently expressed a range of emotions relating to this group throughout the transcripts perhaps highlighting that, as with many categories, this component of evaluatory expression is situational and person-dependant.

Jason expressed annoyance at colleagues of his that he felt used depression as an excuse to take time off work. He hypothesised that for this reason, depression is not taken as seriously as other forms of mental illness;

*'I would say probably a number of people may be claim to be depressed when its not necessarily a clinical depression erm but I think, you know, a proper case of clinical depression is probably higher on the illness spectrum but I think, you know, there's... from what I've seen there's probably, you know, a bit more abuse in terms of you know, 'I'm not feeling too hot today and feeling a bit under the weather and I think I'm obviously*

*depressed' go to the doctors and get you know three weeks off work and 'woo hoo!''*

(Jason: 278-285)

Other participants expressed similar views. Sue gave an example of how she had heard her parents talk about mental illness as a 'choice', and consequently, with ridicule and exasperation;

*'Depressed! There's no time to be depressed!' You know they were too busy working too hard 'you don't know you're born these days!' that type of thing...'*

(Sue: 161-163)

### **3.10 Dyad-specific features**

The benefits of interviewing dyads a generation apart were hoped to be threefold. Firstly, it was hoped that this method would uncover links between patterns of opinion about mental health across generations. Similarly, it was hoped that the use of dyads would help to gain multi-dimensional perspectives on the formation and maintenance of attitudinal beliefs within the same family system, alongside adding to the existing knowledge about the transmission of attitudinal beliefs from parents to children. It became clear that the model was to be built on individual participants' accounts, but key themes emerged as a result of interviewing dyads. These shall be discussed briefly in turn.

Both Moira and Jason, and Sue and Lisa used humour within the interviews either in their descriptions of difficult events that they had experienced relating to mental health issues, or in the way they interacted with the researcher during particularly sensitive parts of the interview. Moira and Jason were both especially explicit about the role that humour played in their family dialogue about mental health and the functions that this served. This was not a topic that they had outwardly discussed, but acknowledged a shared understanding of its importance.

Moira and Jason were also the primary dyad responsible for the creation of the construct 'softening the blow', originally named 'painting an idyllic picture'. The exact function of this remains unknown but is hypothesised to relate to a means of negating stigma associated with mental illness (by highlighting brilliance) or to reframe a difficult memory (aunt institutionalised) with a more positive one. Without further investigation this concept remains unsaturated but provides an interesting link between mother and son not found in any other dyad and therefore suggestive of a shared family coping strategy.

Ann and her daughter Emma both talked of their experiences of suffering from depression. Interestingly, neither wanted the other to know about this and both expressed strong views on mental health as an inappropriate topic of conversation in day to day life. These similarities within family dyads further clarified the subcategories and concepts within the category of '*conditional disclosing*', as they highlighted the important role that familial influence has on assumptions about discourse relating to mental health.

A discussion of the key features of the model built around the core category 'seeking to understand,' including each of the six main categories and the literature relating to each follows.

## 4. Discussion

### **4.1 Overview of chapter**

In this section an interpretation of the analysis will be presented by reviewing the model constructed from the participants accounts of mental health. The core category ‘seeking to understand’ and each of the main categories will be discussed in turn, and their relevance to the literature will be explored. Implications for clinicians providing individual and systemically based therapy will be highlighted, alongside the role that psychology can play on a wider scale in relation to this research. Limitations of the methodology, personal reflections on the research process, and possible areas for future research will also be discussed.

### **4.2 Interpretation of the analysis**

The researcher interviewed seven participants, six of whom were pairs of family dyads, one generation apart. The interviews were conducted separately using an interview guide to focus participants’ responses on their understanding of issues concerning mental health, and what they perceived to be the factors involved in the formation of their attitudes. The interview transcripts were analysed using grounded theory methodology and a model was produced to illustrate what the researcher believed the most resonant features of the participants’ accounts to be.

The model comprised of a core category, ‘seeking to understand’, which was representative of the concept of a constant reflective process, drawing on all available sources, which provides a fluid representation of opinions about mental health across a person’s lifetime. This understanding can be hypothesised to translate into speculation about causality, the process of recovery and attribution of responsibility for symptoms for a person suffering from psychological distress. This ‘evaluatory expression’ is also a fluid process under revision and can be reviewed on the basis of evidence or information which does not fit, or is simply integrated into the previously held beliefs over time. The main properties of each category will be briefly re-iterated

using existing literature to further develop these hypotheses and speculate on the psychological processes which may be underlying them.

#### *Core Category- Seeking to understand*

This category consists of a process of attempting to make sense of the world by drawing on the available evidence. It was constructed by the acknowledgement of uncertainty within all the transcripts in relation to mental health and the frequency of 'hypothesising' statements inherent within the text. Participants such as Moira, who had come across mental health issues more frequently and directly, were perhaps more likely to express a 'formed' opinion than participants without this experience such as Gurdeep. Despite this trend, these opinions remained tentative and speculative in the most part. This process can be hypothesised to be partly as a result of the structural concept of schema formation which is an organised body of knowledge about past experiences that is used to interpret present experiences and as such 'simplify' events. Authors such as Tesser (1988) suggest that schema may be altered every time they are used as further information and inferences are incorporated, further adding to this concept of constant refinement.

Comparisons are made between this process and a vacuum, in which individuals are drawn to add to their current understanding via the basic human desire to make sense of the world. Kelly (1955), proposed that each of us tries to create constructs that make the world understandable and predictable. In this way schema formed about mental health serve to facilitate this process. In a subject as complex as mental health, it can be hypothesised that this circle of 'seeking to understand' never remains static or reaches completion even throughout comprehensive training as in the career of a clinical psychologist.

Participants recounted instances which had prompted them to revise their attitudes. This occurred in one of two ways. Attitudes can be revised quickly and over a short period of time, as in the case of Emma, who experienced depression herself and was 'forced' to review her views of it as it clashed with the self-concept she held of herself as a strong individual. This process can be seen to sit well within the theoretical framework of cognitive dissonance (Festinger, 1957). Dissonance occurs as a result of

the uncomfortable state of holding inconsistent attitudes and thoughts. The motivation to reduce this discomfort results in a change of one of the cognitions.

Alternatively, beliefs about mental health can undergo a more subtle revision as further knowledge, experience and influence is taken on board. This process was commented on by several participants, who recounted the effect that they felt growing older had had on their beliefs and the increasing complexity of those beliefs. Use of the literature may clarify this concept further. Tetlock (1984) studied attitudes about politics to arrive at a concept which he names *integrative complexity*. This refers to the degree to which people have multidimensional views of an issue and integrate a variety of sources of information in arriving at their position. In this way, beliefs about constructs such as mental health, may incorporate conflicting variables that are given equal weight by individuals, and that are both favourable to and unfavourable to the evaluation of the construct. This may, in turn, increase the complexity of a given concept.

### *Main Category- Experiencing*

This element of the model incorporates the importance of experiential learning on belief formation and maintenance. These experiences are split into the influence of personal versus proximal factors and this process was demonstrated by the participant's relation of their current opinions to situations they had direct experience of. Theoretical concepts such as utilisation of heuristics and social learning theory are considered as having a possible role in 'experiencing'.

Heuristics are shortcuts that a person may use to make judgements when they have insufficient or uncertain information on which to base those judgements (Tversky & Kahneman, 1974, 1980). Social perception is therefore aided and made less complex by the creation of categorisations based upon information available, however small the amount. Tversky and Kahneman also suggested two types of heuristic that may be used, the *representativeness heuristic* and the *availability heuristic*. The former relates to the idea that a person may consider some events to be more representative of the population than they really are based on their experience. For example, Moira recognised that her views of mental illness being untreatable are largely based on her

experiences of having a brother with psychosis. The availability heuristic refers to our tendency to be biased by events that are easily accessible in our memory. For example, when asked about her views on mental health, Emma related her attitudes to her recent experience of mental health difficulties for the most part as it was foremost in her mind. It is possible that experience partly functions as a means of developing heuristics about mental health, to simplify the topic further and aid social perception of people considered to fall into that category.

Bandura (1973, 1977) first coined the term social learning theory to suggest that learning can occur by observing the behaviours of others. This theory negates the influence of reinforcement on the learning process and suggests that adopting the beliefs modelled by others may be all that is sufficient to allow attitude formation to take place. In the case of family systems and mental health, it can be argued that observational learning is at least as important as direct reinforcement and is perhaps more common. Supported by the similarity in accounts between dyads and explicitly expressed by participants in some instances, social learning theory appears to be a significant influence in the developing understanding and expression of attitudes by an individual. Social learning theory may also be relevant in the influence of wider systems and conditional disclosing categories. These shall be discussed in theoretical reviews of these concepts.

### *Main Category- Conditional Disclosing*

This part of the model aids the process of seeking to understand by sharing information, and consists of the decisions made about talking about mental health and the messages that this conveys about its perceived acceptability and palatability. Aside from the decision made about 'choosing the audience', ways in which people convey information on this topic were conceptualised as 'choosing a storytelling style', which consisted of several concepts acting to aid this process further. The use of dyads further refined this category as family storytelling styles were highlighted in similar ways by each member. Storytelling styles ranged between dyads significantly, and although they varied depending on circumstance, followed a rough pattern of

virtually no discussion (Ann and Emma), to frank and open discussion (Sue and Lisa) to discussion eased by humour (Moir and Jason).

Again, social learning theory (Bandura, 1973, 1977) may have a large part to play in a person's developing understanding of how to talk about issues related to mental health. This theory is supported by links made within dyads. Several participants acknowledged unspoken family 'rules' about what is acceptable to discuss with others and how this is achieved. It is probable that families have established patterns of this for other topics than mental health, which may also be seen as difficult to discuss.

Despite the apparent strength of this trend across generations it is unlikely to be the only influence present in conditional disclosing. Many participants speculated that their views were different to those of their parents, perhaps as a result of a process of refinement over time. It is of course possible that this is a result of the influence of other categories feeding into 'seeking to understand' such as the influence of society and the media, or experiential learning. The individual nature of attitude formation as hypothesised by the model would anticipate the diversification of beliefs in this way.

Several concepts in this category remain in need of further investigation as did not reach saturation. The researcher was interested in the function that 'choosing a storytelling style' had for the family member, and the ways in which this may be negotiated in times where the rest of the family system was absent. For example, Moira described struggling with this after seeing a film which was particularly upsetting for her as it related to personal experience.

With regards to community storytelling, the researcher discovered a collection of phrases that appeared to be functional for society. These phrases included terms used pejoratively such as 'psycho', 'nutcase' and 'weirdo', and terms used to express humour in some way such as 'nutty as a fruitloaf' and 'crack a jack'. Participants also used the term 'nervous breakdown' to indicate an extreme level of psychological distress reaching breaking point. The use of this terminology conveyed confusion and negative connotations with regards to mental illness and mirrored the findings of Hames & Welsh (2002) and Reda (1996) who found a lack of understanding in the general public with regards to terminology relating to mental health.

### *Main Category- Influence of Wider Systems*

Participants talked of two main factors which impacted on their developing beliefs about mental health. These were; 'media presentations' involving using the media to inform knowledge and linking media images to personal experience, and 'societal standards of normality' incorporating the awareness of stigma.

As hypothesised by Reda (1993), it does appear that the media may have an important role to play in the development and refinement of attitudes. Participants were able to access memories of things they had seen, heard or read which had resonated with them. The impact of these particular media presentations was evidenced by a strong emotional reaction in some cases. Other times, participants were surprised by the content of the media's message. Participants talked of making a 'decision' about whether to accept the information being presented to them to some extent, perhaps suggesting that the media does not have as much power to influence as has been hypothesised previously (Link, 2001). It could also be argued that conscious awareness of this learning process is limited.

Lisa commented on how watching the film 'Silence of the Lambs' had changed her opinion of 'mental people', and how she now believed that they were more intelligent than she had first thought. It seems worth considering the power of representation of certain diagnostic categories on film and television if a fictional character can have such a dramatic influence on a person's global view of mental health. The researcher considered the possible influence of social learning theory and more specifically, modelling from film and television during Sue's interview. She reflected on the film 'Rain Man' and the way Tom Cruise's character responded to his brother who was on the autistic spectrum. She recalled that the character was ashamed of his brother and embarrassed in public. The impact of learning from the media in this way was not investigated further in this study but was of interest to the researcher with regards to the stigma present in modern society. In his article on media portrayal and attitude formation Byrd (1989), suggests that *'portrayals may arouse negative emotion by the context in which they are placed or by modelling that takes place by the actors.'*

The influence of the media was also construed to have positive implications on elements of the model 'seeking to understand' such as conditional disclosing and experiencing, as media reports may also encourage discussion on topics not previously given much thought, as commented on by Gurdeep and Jason.

Participants alluded to a shared understanding of the concept of normality held by society. This included factors such as ability to get by in social situations, ability to hold down a job and acceptability of behaviour. Expectations shared by a collective in this way are learned in the course of interaction with other members of society and are termed 'role expectations' (Biddle & Thomas, 1966). Consequently, if a person does not comply with the behaviour expected of them by society then they may be treated differently and/or excluded. The usefulness of these inclusion criteria for the group consisting of 'normal' members of society may be twofold.

Firstly, previous research has documented the fear that the general public hold towards people with mental illness, perceiving them to be unpredictable and dangerous (Crisp et al, 2000). Although this was not evident in the present study, it may be the driving force between the generation of criteria to identify those that 'fit' into this category. Secondly, the function of the concept of normality may be more easily related to the maintenance of a positive sense of self. Tajfel's (1978, 1982, Tajfel & Turner 1986) *social identity theory*, theorises that the groups that we belong to are an integral part of our self concept, and that discrimination between groups is a result of individual group members motivations to enhance or maintain self esteem.

This concept of normality and the stigma allocated to those who deviate from it was somehow transgressed by having a relationship with a person based on something other than their psychological distress. Participants rejected the concepts of societal norms and stigma when recounting instances where friends and loved ones had suffered, but frequently attributed it to people 'out there'. Hayward & Bright (1997), suggest that findings such as this are unexpected as most research into stigma does not take into account the context that the stigmatiser finds the stigmatised person. This may explain why Crisp's study (2000) did not find respondents who knew someone with mental illness to be more sympathetic and may have important implications with regards to highlighting other attributes present in people in contact with services.

### *Process- Evaluatory Expression*

Within the process of evaluatory expression are the categories of '*hypothesising causality*', '*gauging the possibility of recovery*' and '*allocating responsibility*'. This process is akin to the expression of attitudes and is changeable over time. In this instance, this process was initiated by the interaction of the participant and the researcher during the interview. It can be hypothesised that this process is also generated by suffering from psychological distress personally, or coming across a person with a diagnosis. Albrecht et al (1982) suggest an ordering or continuum underlying negative public reaction to people with different mental health problems. This process was visible in participants accounts in several of the categories which follow and is conceptualised diagrammatically by the use of spectrums.

### *Main Category- Hypothesising causality*

Hypothesising causality is the link between learning of a person's mental health difficulties and making a judgement regarding the possibility and course of recovery based on their beliefs about the diagnosis. It involves making a guess at which factors are most likely to be at the root of a person's difficulties. These causal factors may include biological factors such as genetics and psychological factors such as a stressful working environment. Similarly, causality may be attributed to biopsychosocial factors such as the interaction between environmental stress and a predisposing biological vulnerability, instigating the onset of mental health difficulties.

This process of inferring or explaining the causes of events has been termed *causal attribution* (Heider, 1944, 1958). It is based on the assumption that we all act as 'naïve psychologists' attempting to uncover cause and effect relationships in day to day events, and in this way resonates with the core category of 'seeking to understand'.

Participant's speculations of causality can be conceived to be paralleling professional and academic opinion. Some mental health difficulties are considered to be as a result

of biological influence, such as head injury. Others may be considered to be as a result of psychological crisis, such as post traumatic stress disorder. Furthermore, it is possible to draw similarities between the subcategory of biopsychosocial causality and the stress-diathesis theory proposed in serious mental illness (Zubin, 1986). This theory outlines the role of both biological vulnerability and environmental stress in the onset of difficulties.

A consequence of the category of hypothesising causality may be the consideration of the presentation of origins of mental health difficulties in awareness campaigns. A study by Martin et al (2000) found that the general public are more likely to interact with people with mental illness if they feel it is as a result of structural causes (stress, genetics or biology) than if they believe it to be a result of individual causes ('bad character', 'the way a person was raised'). The authors do not discriminate further within these two categories but what is evident is that hypothesising causality plays a role in the general public's levels of interaction with those in receipt of a diagnosis, rather than diagnosis per se.

#### *Main Category- Gauging the possibility of recovery*

This category pertains to thoughts about prognosis and includes ideas about treatment and hope for recovery. Participants expressed a variety of opinions about the course of the recovery process and speculated on their thoughts about whether a person with mental health difficulties could 'become the person they once were' (Moir: 582-583). Corrigan & Penn (1997) termed this *stability attribution*. If participants viewed this as possible, they also had ideas about how this process may be best facilitated. These speculations varied as a result of who or what the participants were referring to. This can be seen to represent an acknowledgement of difference within the catch all term of mental illness. This category has important implications for individuals beginning therapy, family members of individuals receiving a diagnosis and wider societal opinion. This shall be discussed further at a later point.

Most of the participants quoted professional involvement as an essential step in the management of mental health difficulties. Gurdeep was the only participant to recommend family intervention before seeking professional help. The researcher

hypothesised that this may be due to cultural differences in the role of the family, and perhaps an alternative perception of mental health across cultures. However, as Gurdeep was the only participant from an ethnic minority, this hypothesis was unable to be developed and remains just that. It is of course possible that Gurdeep's lack of experience of issues relating to mental health may lead him to express more 'naivety' in the requirements of this group than other participants who have witnessed it first hand.

An interesting point relating to this category is that the researcher assumed that if the participants cited biological causality they would make reference to the use of biological interventions, and similarly if they cited psychological causality they may reference psychological interventions. This was not the case, and in fact, only one participant mentioned the potential benefit of talking therapies for a person experiencing psychological distress. Talking as catharsis was mentioned as something that occurs with family or friends, and professional involvement was stated to include the use of medication and being sectioned under the Mental Health Act. This may have potential implications for clinical psychology in general. The profession may need to increase the visibility of psychological interventions as an effective means to relieve psychological distress within the general population.

Norman & Malla (1983) researched Canadian teenagers' attitudes towards mental health using vignettes. They discovered that perceived severity of mental illness is positively correlated to attribution to physical causes, and negatively related to social acceptability. In addition, beliefs in psychosocial causality correlate positively with optimistic beliefs about prognosis. This would help to explain both the reasoning behind attributions in the hypothesising causality category, the ideas contained within the spectrum of hope and process of recovery in this category and ideas pertaining to blame contained within the category of allocating responsibility.

### *Main Category- Allocating responsibility*

Participants appeared to use the categories of hypothesising causality and gauging the possibility of recovery to come to a decision about a person's role in their own mental health. That is, individuals are placed on a spectrum ranging from completely blameless, to responsibility for symptomatology and recovery being located within them. As a consequence of this, the evaluator may then have an emotional reaction towards the individual, such as compassion or annoyance. Rose et al (2002) discovered that families coming to terms with a members mental illness reached a stage where they made decisions about who was responsible for managing the illness. They were found to be less willing to accommodate behaviours and attribute to 'illness' and more likely to attribute behaviours to a degree of manipulation by the diagnosed.

Theoretically, this category can be related to the concept of locus of control (Rotter, 1966) which proposes that events in life are explained by internal or external causes. In this sense, an individual is perceived to have a variable influence on their situation. A study by Weiner et al (1988) found that within the general public there is discrimination among disability groups, and that people with mental illness are viewed most harshly. This was due to *controllability attribution* which reflected the amount to which the general public perceived the person, or outside forces (such as the environment or biological disease agents), responsible for symptoms. The authors reported beliefs that people with mental illness are to blame for their disorder, should not be pitied and should be avoided. Corrigan et al (2000) also found evidence of perceived controllability, which comprises of avoidability and blame.

Interestingly, Johnson (2000) found that males were more likely to interpret mental illness as a lack of motivation rather than a biological illness. The current study did not have enough male participants to be able to examine the reasoning behind this trend further, but Jason did express fairly unsympathetic views to certain presentations of depression, believing that people were malingering and using the label to get time off work.

### *Reflections on the model as a whole*

The model 'seeking to understand' attempts to explain factors involved in the formation and refinement of attitudes towards mental health and illness within the general public. Previous literature had hypothesised the role of family influence, knowledge, social contact and media influence but this area still remains under-investigated for the most part. The current research has highlighted all of these factors as influential in participants' accounts, and has suggested the importance of attitudes when making judgements relating to psychological distress. These judgements are based upon ideas about causality, responsibility, blame and prognosis and can be hypothesised to translate into stigmatising behaviour. A crucial feature of the model is its fluidity and therefore the suggestion that it can be revised by the introduction of dissonance to one of the categories. This has wide reaching clinical implications.

## **4.3 Implications**

While the focus of this study was not on persons receiving input from clinical services there are a number of implications for clinical practice and wider professional consideration. These take the form of implications for clinicians working with individuals in therapy, implications for clinicians working with family systems, and the impact psychology as a discipline can have on wider societal opinion. These will each be discussed in turn with recommendations for clinical and organisational practice.

### *For clinicians seeing individual patients*

From the outset the stigma in society regarding issues relating to mental health has been shown to have a detrimental effect on persons receiving a diagnosis (Marrone, Balzell & Gold, 1995; Read & Baker, 1996; Birchwood et al, 1993; Link et al, 1997; Farina et al, 1981; Link et al, 2001; Link, 1987). This may take the form of social exclusion and disadvantage to the confirmatory effects of labelling theory. However, before a person receives a diagnosis, their beliefs about mental health, their

experiences of how acceptable it is as a subject of discussion and their feelings about responsibility for symptomatology may have a significant impact on their help seeking behaviour. Sue recalled her mother's distress at being held under the Mental Health Act due to the visibility of an ambulance outside her house. Similarly, Emma spoke of the time it took her to visit her GP when she realised she was in need of help.

Individuals who do access psychological input will arguably arrive in the therapeutic consultation room with their own conceptions and misconceptions about mental health based on their previous history as detailed by the model. During assessment, clients are often asked their opinions on what they believe the origins of their current distress to be but are perhaps rarely asked their opinions on other aspects of their difficulties such as treatability. This will undoubtedly have an impact on the success of any therapeutic programme as clients may come to the service with an expectation that therapy will fail, or contrastingly, 'cure' them of symptoms forever. Such belief systems should be made explicit so that they can be addressed within the therapeutic relationship.

#### *For clinicians considering systems*

All service users exist within systems and whether the therapeutic input is tailored to the wider system or to the individual clients will be receiving feedback either implicitly or explicitly from those close to them. Clinicians could potentially give more consideration to how spouses and family members may be reacting to the individual's current situation as it may have a further impact on self esteem, feelings about attending therapy, and decisions to attend or invest in therapy.

Rose et al (2002) used grounded theory methodology to investigate families' responses to their relative with severe mental illness and discovered that the most distressed family members saw their relative as 'a child who was unpredictable, not responsible and who would not significantly improve in the future'. This was similar to the findings of Badger (1996) who found that being able to find hope was indicative of families coping successfully. This research highlights the potential benefits of sharing knowledge, formulations and intervention plans with the family if consented to by the client. Several studies have discovered that an over emotional and

criticising expressed attitude by the family of people experiencing psychosis increases the risk of relapse (Brown, Birley & Wing, 1972). Furthermore, such attitudes further hinder coping by a reduction in family help seeking behaviour due to the anticipation of negative reactions from others (Chafetz & Barnes, 1989; Rose, 1998)

*For psychology interacting with wider systems*

This study also suggests that psychology has a potential role to play in reducing stigma in society. Crisp's (2000) study has documented the prevalence of stigmatising opinions within the general public and these views were reflected to a certain extent in the text. The difference perhaps in the present study was that participants commented on the importance of '*knowing the person*' on the content and expression of their beliefs. This may have implications in the presentation of other attributes of the individual apart from their mental health status to staff, families and work colleagues.

There are several important wider systemic implications based on three of the main categories. Firstly, there is a need for psychology to adopt an educational role and to present the general public with information about mental health with the intention of challenging stereotypical attitudes. This should include the policing of negative and inaccurate media portrayals. This information would seem best targeted at education around causality, attributions of stability and controllability and the benefit of talking therapies. This is a task already undertaken by the British Psychological Society to some extent whose press office provide a consultation service for the media with regards to acceptable and unacceptable portrayals of mental illness on British television.

Secondly, there is a potential role for the opening up of a discourse about mental health on a wider scale. Participants reflected on the restrictions implicit in language pertaining to the discussion of matters related to mental health and illness. These restrictions further serve to maintain the stigma and stereotype around this topic and also prevent the communication of knowledge which could potentially encourage a review of these beliefs. Previous research has also discovered confusion with regards to terminology used by professionals. The profession should consider ways to open up

a dialogue about mental health and use it to clarify and demystify language pertaining to mental health.

During clinical training, the consideration of personal attitudes and raising awareness of the stigmatisation and beliefs of general society as a whole may be useful when preparing to see clients for individual therapy. For example, as the researcher found, throughout training our own attitudes about mental health may have changed significantly from previously. It may be fruitful as training clinicians to recognise how education and experience have shaped current beliefs in this way, and how within a session, clients may hold very contrasting ideas which clinicians may not be aware of. These could act as barriers to therapy if gone unrecognised.

The indication that these stigmatising opinions may be present in health professionals to a large extent (Jorm, 1999) uncovers an area of potential clinical relevance. Referrers may have inaccurate perceptions of causality and treatability based on their own understandings of mental health, leading to unsuitable referrals or inappropriate gatekeeping. The experience of being a service user in a mental health setting with such attitudes may itself be a contributor to the erosion of self-esteem.

#### **4.4 Methodological considerations**

As has been outlined, a core component of grounded theory is using theoretical sampling to recruit participants on the basis of developing the emerging theory (Glaser & Strauss, 1967). Drawing on divergent perspectives allows the researcher to gain a fuller picture of the properties of the core categories and encourages the likelihood of coming across a perspective that may challenge the researcher's developing beliefs (Fielding & Fielding, 1986). In this way, this method of sampling provides both a means of ensuring rigour and allows the further development of the theory. Within the present study, theoretical sampling was used to select the last three participants. This was an appropriate stage to begin sampling in this way (Charmaz, 2001, 2003) The researcher was aware that the first two dyads were of a similar age

range and had fairly high levels of academic achievement. This led the researcher to question what an older dyad may add to the emerging theory in light of previous research on the effects of age on stigmatising beliefs (Crisp, 2000; Yarney, 1999; Hainge, 1997; Norman & Malla, 1983). The assumptions that the researcher had prior to these interviews as a result of these findings and personal opinion will be discussed at a later stage. Similarly the effects of education on attitudes was considered. The first four participants were highly articulate and the researcher was unclear at times whether these accounts were presenting an opinion that was socially acceptable rather than personal.

The last dyad was recruited after an acknowledgement that the model was being constructed solely on the basis of accounts from white individuals of UK origin. Considering the effects of cultural identity on attitudes about mental health mentioned earlier (for example, Kagan, 1984; Ollendick et al, 1996) it seemed that gaining this different perspective may question the properties of, or add to existing categories. Ultimately, Gurdeep's interview was not used to a great extent in the analysis. The reasons for this are hypothesised at a later stage. Gurdeep and his son were also approached as it was speculated that a father-son dyad might have provided further insight. However, Gurdeep's son chose not to take part in the study due to work commitments. The researcher acknowledges the limitations of the sampling in terms of the applicability of the model to all communities and considers the potential benefits of repeating this research with other ethnic groups at a later stage.

Without the time constraints of a doctoral thesis, the researcher may have gone on to interview more participants to develop existing categories to saturation further. Aside from hearing from individuals from a variety of ethnic backgrounds, the researcher may have considered interviewing mental health professionals, adolescents or service users themselves in light of previous research (Townsend, 1990; Jorm et al, 1999; Norman & Malla, 1983). The use of dyads raised interesting issues throughout the analysis. Further sampling of dyads may have generated hypotheses for future research, perhaps considering the intergenerational transmission of communication styles relating to mental health. Deviant cases were considered during the analysis, and are considered to be a further means of enhancing quality and validity (Mays & Pope, 1995; Silverman, 2000). Such cases were used to encourage the researcher to

search for contrasting themes within the developing theory, thereby encouraging the researcher to question previously held assumptions about the data. Attempting to incorporate and explain varying data in this way further aids the development of existing categories (Mays & Pope, 1995).

Participants were not known to the researcher but recruited by friends and colleagues. Memon & Bull (1999) suggest that reflecting on interviewees reasons for participating in a study further enhances quality in qualitative research. The researcher considered that in many respects the participants were doing the researcher 'a favour' and may, to some extent, have strived to provide accounts which corresponded to what they believed the researcher expected to hear. The use of grounding categories in the data and being mindful of contradictions within accounts assisted in raising awareness of such effects.

The interviews varied in length and depth of response fairly significantly. Moira was the first participant to be interviewed and her interview was also longest. This appeared to be as a result of her varied experience on this topic plus her eagerness to discuss the topic. Gurdeep's interview was the shortest, perhaps because he had no particular experience to draw on, making it difficult for him to reflect on his opinions in this way. Gurdeep also felt quite strongly that he should not be expressing views on this topic, as it was not his area of professional expertise. This was in contrast to all the other participants, who seemed to find voicing their opinions fairly easy. This added further weight to the concept that the process of seeking to understand is aided by experience.

Throughout the interviews, questions asked varied from the topic guide at times. This enabled discussion that was conceived as more participant-led and can be seen as a means of encouraging greater epistemological reflexivity. Despite the concept of undertaking grounded research in the absence of an *a priori* hypothesis, this is highly improbable in practice (Glaser & Strauss, 1967). Consequently, the researcher began the interviews with some initial thoughts about what may arise based on a brief review of the literature. The researcher attempted to combat the potential bias resulting from this by following leads presented by the participant. However, as the researcher was not interviewing people about their personal experience *per se* (for

example, service users experience of therapy), some element of prompting was required. This was due to the fact that participants did not come to the interview with an agenda for what they wanted to discuss, and in fact may not have given a great deal of thought to the concept of mental health prior to the interview.

Seven participants were interviewed altogether. The core category 'seeking to understand' was considered to be saturated however, several of the main categories, in particular 'conditional disclosing' required further investigation. Rennie, Phillips and Quartaro (1988) have suggested that saturation begins to occur after 5-10 interviews, although saturation can be viewed as more of a goal than a reality (Willig, 2001). Seven participants can be considered an appropriate number for qualitative methods in a doctorate thesis (Turpin, Barley, Beail, Scaife, Slade and Smith, 1997).

## **4.5 Reflexivity**

Using Willig's (2001) distinction between reflecting on how the researcher versus the design of the study has impacted on the emerging theory, this section considers personal and epistemological reflexivity in turn.

### *Personal reflexivity*

The researcher felt that conducting a piece of qualitative work had inevitably prompted personal consideration of research methods in general, and particularly how qualitative methods appeared to be more congruent with her view of psychological investigation by nature of their emphasis on the personal. Alongside this, the researcher observed implications of being invested in this research process on her clinical practice, specifically giving more consideration to the meaning clients were trying to convey with their language rather than the speech itself. Henwood & Pidgeon acknowledge that the use of qualitative methods should have a personal impact on the researcher (Henwood & Pidgeon, 1992).

The researcher initially set out to interview members of the general public without personal experience of suffering from mental health problems as this seemed to be the

best method to gain an understanding of how people with no specific experience or training view mental health. The researcher underestimated the wealth of experience most participants would have to draw on, and that two of the participants would disclose their own experiences of mental health. These accounts proved invaluable as they demonstrated the fluid nature of the model and allowed an insight into the role of proximal experience.

Similarly, the researcher used her field diary to document the assumptions that she had prior to the interview with the dyad of an older generation. As documented previously, prior research had speculated the effects of age on attitudes about mental health, with some conflict of opinions about whether older people or younger people are more likely to hold stigmatising beliefs. The researcher was surprised by the accounts of Ann, who she incorrectly assumed would oversubscribe causality to the medical model. Using the field diary in this way encouraged a greater awareness of the potential bias inherent within the researcher's assumptions.

Similarly, the use of supervision and a monthly qualitative research methods group enabled the reflective process further. Only one participant mentioned the use of professionals within the 'talking as catharsis' sub-category. The researcher had initially included this within the model but after supervision, concluded that this inclusion was indicative of the researcher's assumptions, rather than one grounded in participant's accounts. As mentioned previously, the use of supervision and research groups further enhances rigour by decreasing researcher bias and offering alternate perceptions (Hoshmand, 1994; Stiles, 1993).

### *Epistemological reflexivity*

Psychosis was referred to most frequently by most of the participants. There could be several reasons for this. Firstly, previous research has found that individuals often believe all persons with mental illness to have psychosis (Reda, 1996). Secondly, Jason hypothesised that psychosis is the most frequent diagnostic category that the public is 'bombarded' with media imagery (Jason: 33). For the purpose of opening up discussion, if it was felt that the participant was referring only to one form of presentation the researcher introduced other commonly heard of mental health

difficulties at a later stage of the interview. The researcher initially feared that using diagnostic categories in this way could be both leading participants' responses and colluding with language laden with pejorative images and stigmatising beliefs. Emma's account however, provided evidence for this as a helpful interview strategy, as prompting her in this way encouraged discussion of relevant experience that she had not previously volunteered (Emma; 98-109). The researcher then revised her opinion, and considered that the very nature of participant's uncertainty about what constitutes mental illness led to them neglecting to include potentially relevant information in interviews.

It is possible that the participants expressed tentative opinions as a direct response to their knowledge of my professional position in the interviews. This may mean that their expectation of my knowledge on the subject being superior to theirs may have resulted in them being more cautious when expressing attitudes. Perhaps in the company of others that they viewed to have similar, or lower levels of knowledge, they may have appeared to be less speculative and less prone to hypothesising. This power imbalance in interviews has been documented by several authors (for example, Henwood & Pidgeon, 1992)

Throughout the interviews potential leads concerning religion and culture were not followed within the interview process. This was a result of the researcher's acknowledgement that this area of investigation was too rich to do justice as item on the interview guide with a small number of participants. During an initial literature search, this area was considered as a potential research topic as many authors have documented the variations in perceptions of causality, prognosis and treatment across cultures (Kagan, 1984; Ollendick et al., 1996; Sheehan & Kroll, 1990). Moira and Ann particularly talked of the role of faith and the church in issues relating to mental health and it seems this may be one of several areas of interest for future research.

#### **4.6 Suggestions for future research**

The present study raises several potential areas for further research. Firstly, further interviews are required to reach saturation in the categories of 'conditional

disclosing', and in the sub-categories of 'awareness of stigma', particularly in relation to the concept of 'knowing the person'. Further analysis into these areas may provide separate research projects in their own right in terms of the language used to talk about mental health. In terms of 'conditional disclosing', it may be that an alternative method of investigation, such as Discourse Analysis (Potter & Wetherell, 1987) may serve such a topic more appropriately due to its focus on what people 'do' with language. An interesting area of study in relation to this category may be to investigate how families use storytelling styles in more detail, especially in the utilisation of such strategies outside the family system. Moira recounted a difficult situation where she was unable to use an adaptive strategy at a time when she was in distress. With regards to 'awareness of stigma', further research investigating the importance of 'knowing the person' could be hypothesised to play a potential role in efforts to combat stigmatisation.

It is possible that the process 'seeking to understand' and its components may be generalisable to how people attempt to understand other widely experienced social phenomena such as aspects of parenthood or ideas about death and dying. Similarly the investigation of the development of potentially stigmatising attitudes may be relevant in future research into other areas of widespread negative public attitudes such as HIV infection (for example, Lalljee & Palmer-Canton, 2001). Haug (1987) has refuted claims that the findings of small scale qualitative research methods are not generalisable by stating that 'if a given experience is possible, it is also subject to universalisation' Haug (1987: 46)

Differences have been found in cultural stereotypes of mental illness across nations, but there appears to be a lack of research into the extent of stigmatisation within ethnic minorities in the UK, and the extent to which these vary from the attitudes of white, British residents. Research into conceptions of aetiology, perceived dangerousness, prognosis and degree of control may provide useful input to health promotion campaigns in such communities. Cultural issues and the influence of religious beliefs were not considered in the present study but may provide an interesting area for future research. It is essential for clinicians to appreciate the beliefs that a client and those close to them hold about their distress and its course, outcome and causality to encourage maximum benefit from therapeutic intervention.

On a more clinical level, research into how a client's conceptualisation of their own mental health may help or hinder the therapeutic alliance may be required. It may be of interest to use quantitative methods to rate client's beliefs about their symptoms and their optimism about therapy based on several of the main categories of this model. Such research would, of course, need to take into account the role that their symptomatology may be having in influencing their feelings about prognosis generally, as in the case of cognitive distortions in depressive episodes (Beck, 1976).

Finally this research highlights an individual conceptualisation of attitudes about mental health based on several key factors. Its implications with regards to beliefs about causality, prognosis and responsibility suggest an emotional reaction to the person in receipt of a diagnosis. The clinical implications of this are widespread and suggest future research focuses on developing these themes further. Such research may have an important contribution to mental health promotion, combating stigmatisation and maximising the success of therapeutic interventions.

## **Appendix One – Participant Information Sheet**

**HOW DO FAMILIES TALK TO EACH OTHER ABOUT MENTAL ILLNESS? AN  
INTERVIEW STUDY**

**Principal Investigator**

**Karen Gurney, Trainee Clinical Psychologist, Department of Clinical Psychology,  
University of Leicester, 104 Regents Rd, Leicester, LE1 7LT.**

**Telephone: 07831 615069 - For Further Information**

I am interested in how people's attitudes towards mental health are influenced by family members, particularly across generations (i.e., from parents to children). Hence, I am hoping to interview family members to find out their experiences of this. I would therefore like to invite you and one of your parents/adult children to take part in this study and to be interviewed separately on your experiences.

**1. What is the purpose of the study?**

The purpose of the study is to investigate the influences that may have a bearing on the formation of attitudes. It is interesting to discover how families discuss matters such as this when there is an absence of a mental health problem will perhaps be transferable to families where one or more of the family unit *does* have a mental health problem. In some instances family member's beliefs or reactions to a diagnosis may help or hinder recovery and it is perhaps these families that could benefit from a more family orientated intervention package from psychologists.

## **2. What will be involved if I take part in the study?**

I will approach you and ask you if you are interested in being involved in the study. After reading this information sheet, if you and a family member are interested in participating in the study, I will contact you to arrange a time to meet. I would like to interview you separately to ask your *opinions* about mental illness rather than 'right or wrong' answers. I would like you to have no formal training in mental health issues. Also, if you are currently receiving input from mental health services (or are the primary caregiver of somebody who is), it may not be appropriate for me to interview you. We can arrange to meet anywhere that is most convenient to you (e.g. at home, at the university).

When we first meet, I will provide time to answer any questions that you might have about the study. I will then ask for your consent to be interviewed and for the interview to be tape-recorded. Once this is agreed, the interview will begin and should take around an hour. I will ask you questions such as "How have your opinions towards people with a diagnosis of mental illness changed over time?" and "Do you feel you hold views about mental illness that are similar to those held by your parents?" After the interview is finished, I will provide some more time in which I can answer any further questions that you may have about the study. I will also ask for your permission to contact you again to arrange another interview in the future. I will only arrange a second interview if there are areas from your first interview that I wish to follow-up. You do not have to agree to this second interview if you do not want to.

The interviews will be transcribed and analysed. The ways in which families influence each other's attitudes will be presented in a written format. This will encourage further understanding of how attitudes towards mental illness may be shaped and/or changed over time within the family unit.

## **3. Will information obtained in the study be confidential?**

Yes.

Only I will listen to the tape-recording and the tape will be kept in a secure place. Your name and any other identifying material on the transcription will be changed to protect your confidentiality and will also be kept securely. Family members will not be told what either members of their own family or other interviewee's have said.

**4. What if I am harmed by the study?**

It is hoped that the interview will not be upsetting to you, however, if you are upset and would like to talk further, I can arrange to see you again.

*Medical research is covered for mishaps in the same way for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.*

**5. What happens if I do not wish to participate in this study or wish to withdraw from the study?**

If you do not wish to participate in this study or if you wish to withdraw from the study you may do so without justifying your decision and your future treatment will not be affected.

## **Appendix Two – Consent Form**



University of  
Leicester

Karen Gurney  
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University of Leicester  
104 Regents Rd  
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Tel: +44 (0)116 252 2185 (*Course Secretary*)  
Tel: +44 (0)116 252 2492 (*Placement enquiries*)  
Fax: +44 (0)116 223 1059

### Consent Form

Study to investigate the transmission of attitudes about mental illness across family generations in the general public.

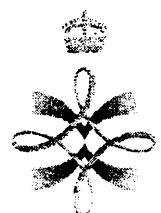
I agree to be involved in this research study, and to therefore be interviewed by the researcher, Karen Gurney. I am aware that I am able to withdraw from the study at any time and I will not be discriminated against in this, or in future studies.

I consent to the interview being tape-recorded and transcribed by the researcher. The tapes will be securely stored and listened to be the researcher only. The transcripts will be anonymised and the researcher will remove all identifying details in the transcripts.

As part of the researchers training, I agree for my interview transcript to be included as an appendix in her thesis, which will be submitted to Leicester University in June 2004. On withdrawal from the study, or after the interview has been transcribed, the researcher will erase the recording from the tapes.

Further details of this study can be discussed with Karen Gurney on 07831 615069.

Signed.....(Participant) Date.....



THE QUEEN'S  
ANNIVERSARY PRIZES

1994 & 2002

### **Appendix Three – Example of line by line coding**

88. the family when you were younger?

89. I don't actually remember (.) erm (.) I think I just heard that he'd had a

90. break down he'd been some accountant quite a whiz or something and

91. erm it was may be portrayed to me/may be as that the pressure became

92. too much and he'd had a some kind of breakdown but the nature of what

93. that breakdown is or what or when it was said that it was paranoid

94. schizophrenia that probably came at a later date I certainly remember

95. erm tales of him like sitting in a police cell and like my uncle michael

96. the policeman being called to come and bail him out after he'd had one

97. of his episodes erm but I can't remember how I first became aware of it.

98. Right. But you were quite young then?

99. I think so (.) I mean certainly before 14 I would expect but it could have

100. been earlier I don't know.

101. This might be more difficult to answer again but do you remember what

102. you thought of it at the time?

103. (.) I think not disturbing or upsetting but erm you kind of think how or

104. why does that happen to somebody and erm you obviously feel sorry for

105. them and the people that are close to them for being in that situation.

106. And do you think you came to any ideas at the time about how or why

107. that came to happen to your uncle?

108. Not that I'm aware of now may be at the time I thought you know how

109. did that happen but I don't think so but erm you know I still don't know

110. how or why it happened.

111. Right. And was it something that was talked about quite openly as a

112. family or did you not really discuss it that much?

113. Not really I don't think and certainly not in a serious type matter erm the

114. only time it would be discussed would be more in a light hearted matter

115. where tales had been told and it sounds bad to say entertaining but erm

116. you know there were some quite funny tales about my uncle going off

117. having his episodes and sitting with beelzebub next to him in the police

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