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PROFESSIONAL PROCESSES AMONG THREE OCCUPATIONAL GROUPS WITHIN THE MENTAL HEALTH FIELD

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A Thesis Submitted for the Degree of Doctor of Philosophy

The City University

The Department of Social Science and Humanities

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ABSTRACT

This thesis is a study of professional processes among the occupations of psychiatry, clinical psychology and social work. There is an initial review of the past studies on professionalisation and psychiatric ideology, and it is argued that there is a need for a socially grounded approach to the study of professionalisation, through an analysis of the ideologies to be found among the members of these occupations. The past development and present position of each of these occupations is then considered, and attention is drawn to the differences both within and between them. The substantive findings of this study, derive from the interviews with 38 psychiatrists, 38 social workers and 27 psychologists, working mainly in mental hospital settings. Seven different ideologies, that were discovered among these staff are described; the 'doctor' and 'eclectic' ideology among the psychiatrists, the 'welfare worker' and 'therapist' ideology among the social workers, the 'tester' and 'professional' among the psychologists and the 'dissident' ideology that was found among all three groups. Attention is directed to the way the ideologies represent different 'definitions of the situation', and the way they justify or reconcile disparities of power and influence. Accepting that the psychiatrists are the 'key audience' for the lay staff, their view of the latter's role is examined, and further the way they defend their own dominance. These issues are then explored from the point of view of the social workers and psychologists, in order to identify how far they legitimise the psychiatrists' claims, and further the extent to which they pose a challenge to them. The question of the professionalisation of social work and clinical psychology is then considered through an analysis of their social structural position within the hospitals. The processes of 'personalisation', 'particularisation' and 'accommodation' are identified and described as providing evidence of the way the status quo within psychiatry is maintained.

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CHAPTER 1

THE AIMS AND PERSPECTIVE OF THE STUDY

> "I think that mental illness is a personal and social problem and that to see it as a medical problem, is to remove from it the personal and social factors involved in the distress of the person." (2802)
>
> "Psychiatry is very absolutely essential for the treatment of mental illness as the patient has first to be assessed as whether or not they are ill. Only a psychiatrist can decide the diagnosis and the initial treatment to be given - this must remain in the hands of the doctors." (1603)
>
> "If psychiatry is meant to be becoming more social psychiatry, then a social worker with better training would be better suited to having a dominant role than a predominantly medically trained person would." (3504)

These quotations are taken from interviews with a clinical psychologist, a psychiatrist and a social worker respectively. In their various ways, these quotations point to the main themes to be explored in this study. At a very general level this study is concerned with how mental illness is treated, and in particular with how it is that the medical model has dominated the way madness has been dealt with. The focus of this study though is not on what actually happens to patients, but rather on the staff who in various ways claim to have a part to play in the treatment of patients. The treatment of patients does not occur in a social vacuum, instead treatment arises as a consequence of the structure of staff relationships that either foster or hinder a particular approach being taken. For this reason a central theme of this study is an analysis of the way in which the medical profession continues to dominate, and largely define, the terms on which mental patients are treated. Such an analysis can itself be illuminated through an examination of the position of those staff, who are in the best position to challenge the medical profession, and pose an alternative approach to understanding

and coping with madness.

This study is therefore about, if somewhat indirectly, the way in which mental patients are treated. More immediately though, it is about the control of one occupation over the institutions in which the majority of mental patients are contained. The authority that rests in the hands of psychiatrists stems largely from the Mental Health Act, 1959, and thus one approach to studying this question would be to examine the social processes that led to this Act (1). However, the focus of this study is on the contemporary situation, and it was decided to approach this question from the perspective of a study on professionalisation. If professionalisation is taken to be about establishing control over the application of certain knowledge and skill, then the most appropriate way of approaching the question of why a particular occupation is in a dominant position over the treatment of mental illness, is to examine the structure of professional relationships and processes to be found within the main settings in which treatment is carried out (2).

It has been asserted that psychiatry is in a dominant position over the treatment of mental illness. Such an assertion like all assertions needs to be qualified. In particular it could be noted that psychiatry may be dominant in mental hospitals, but outside their walls, other occupations play a more important role in the identification, treatment and care of 'mental illness' (3). But at the present time, mental

(1) In Chapter 4 there is a brief account of some of these processes.

(2) In Chapter 2 there will be a more detailed discussion of the question of professionalisation.

(3) Surveys of the 'incidence' of mental illness suggest that psychiatrists only handle a very small proportion of it. See, for example, Ransom (1971) and Shepherd and Cooper (1964).

hospitals are the most important institutional means of containment, and for the purpose of this study, are the main treatment locales where the members of the three occupations of psychiatry, social work and clinical psychology come together. Indeed, clinical psychology as a specialist, applied branch of psychology has largely developed within mental hospitals, and thus the course of its professionalisation has been shaped as a consequence of its emergence within institutions over which it has no control. Psychiatry itself arose as an occupation that was largely concerned with 'asylum science', and although it has branched away from asylums, its history has largely been contained with them. The situation of social work is a more complex one. Recent changes in the organisation and administration of the occupation have located the centre of all social work in the 'community', within local authority departments of social service. If the Association of Psychiatric Social Workers was still in existence, then the problem would have been much easier as the history of this specialty was more closely tied to the other two occupations, than that of the new generic social workers. These matters will be considered in more detail further on (1); they have been raised now in order to introduce the point that mental hospitals are appropriate settings in which to study the processes surrounding the professionalisation of these occupations. All three can be regarded as emergent professions; psychiatry may be more established and also have more power but it is still an 'outsider' compared with other branches of the medical profession. As Sir Aubrey Lewis has observed:

(1) In Chapter 4.

> "Psychiatry, which may in many respects fairly be regarded as in much the same state as medicine at the end of the eighteenth century, cannot be presented to the medical student as an adequate theoretical system or as a body of established and classified facts about causes, pathology, course and treatment of mental diseases" (1).

In recent years many psychiatrists have claimed that they have now been integrated with medicine, but even if it is now a more medically respectable pursuit, most observers on the state of 'psychiatry' and the treatment of mental illness, are led to conclude that there is considerable confusion, uncertainty and lack of agreement over the very existence and meaning to be given to 'mental illness', quite apart from how it should be treated (2).

One aim of this study is therefore to examine the nature of the claims that members of the occupations of social work, clinical psychology and psychiatry are making for themselves. This is a necessary task, for only then can a comparison be made between these occupations when considering the positions that they currently occupy in relation to one another. The approach taken to gathering data on these claims was that of interviewing. This meant that while some observations were made of the working situations and daily actions of the members of these occupations, the study is primarily about what they said of themselves, and thus is more about ideas than actions. The study of ideas though cannot be divorced from the social context that gives rise to them. Conversely, the study of the social context, or as it is usually termed, the social structure, also requires a study of the ideas that men hold of that structure. One of the merits of the recent interest shown by

(1) Quoted by Shepherd in Davies and Shepherd (1963), p.124.

(2) Coulter (1973) has provided a very thorough review of the whole field.

sociologists in phenomenology has been the increased attention placed on the way that men construct the world that they live in through their daily actions and understandings of that world (1). Without slipping into a form of psychological reductionism, it can be asserted that sociologists should pay more attention to what the participants themselves have to say about the situations that they study. The reason for doing this is not merely to gain more illuminating insights than a more 'objective' questionnaire method would allow, but rather to explore the way that acting members of society invest their actions with meaning and intentionality. On the one hand such an approach could be taken to be a plea for a more qualitative as opposed to quantitative methodology, but on the other it can be taken as a plea for the development of a sociology that is fully aware of the 'interpretive' and problematic basis of social life, as opposed to one that stresses the 'normative' and systems determined elements (2). Following Weber (1964) this study is in part concerned with the interpretation of the subjective meaning of behaviour as found in the intentions of actors, but unlike the phenomenologists who have retreated into subjectivism by denying the reality of any structure within society, other than that which exists in the minds of members of that society, this study aims to take due account of the existence of structural factors that act as constraints upon an individual's freedom of action.

The problem of identifying the relationship between ideas and actions has had a long history in sociology. It has recently been

(1) Berger and Luckman (1967) have become the best known popularisers of this view for sociologists.

(2) These issues have been discussed in different ways by Dawe (1970) and by Wilson (1970).

argued by Brittan (1973) that the problem of consciousness, which is another way of describing this problem, is a central one in sociology. Somewhat similarly Taylor et al (1973) have discussed this problem in their formulation of the requirements for a 'fully social theory' of deviance. While attempting to develop a 'Marxist' theory of crime that gives due priority to dominance of economic relationships in industrial societies, they also stress the need for a transactional social psychology that will give due emphasis to the motives, intentions and actions of deviants and the agencies of social control. However, there are times when the accounts that actors give of their actions or motives appear to blatently misrepresent the nature of their situation. For Marxists, the concept of false-consciousness provides a short hand way of dismissing this problem, but as C W Mills (1940) has pointed out, 'vocabularies of motives' exist within society, to be called upon and used as justifications for actions. Thus the study of the ideas, accounts, the assumptions and beliefs, in other words the ideologies, that people hold, whether or not they are 'true' or reflect the 'reality' of their situation, can be seen as contribution towards the study of consciousness. One of the tenets of phenomenology and its derivative ethnomethodology is the claim that sociologists know no more about the world than the participants of that world (1). But as Rock (1973) has noted, sociologists can often see beyond the confines of the acting member's world and thus see contingencies acting upon it, of which the actor remains ignorant. Other sociologists have called such contingencies 'institutional imperatives' and have suggested that phenomenological and also symbolic interactionist

(1) For example, Matza (1964, 1969) in his studies on delinquents, has attacked sociologists for imputing meaning to the actions of deviants instead of accepting their own accounts as being the genuine ones. But Box (1971) has pointed out how Matza is inconsistent in his own terms.

explanations are not sufficient, unless they also take account of such contingencies as the allocation of resources, or existing authority relationships (1).

It has been necessary to raise these more theoretical issues as they indicate the general problems this study raises. As the title of this thesis suggests, this study is concerned with certain professional 'processes'. This term was chosen as it draws attention to the changing, developing and transactional basis of the way in which occupations seek to establish themselves as professions. Process models have, however, been attacked for failing to take account of structural considerations and for presenting an individualistic and liberal view of society and social relationships (2). But, while it may be accepted that such criticisms are relevant to much symbolic interactionist theorising, it can still be argued that the study of processes can contribute towards an understanding of structures. To take the case of the mental health professions as an example, psychiatrists are invested with legal authority over the fate of patients, and thus can determine and largely decide which other members of staff can have contact with 'their patients'. But it would be a gross caricature of the situation, to present either social workers or clinical psychologists as being oppressed by the psychiatrists, or as being without any power, as an application of Dahrendorf's (1957) zero-sum model of authority in 'imperatively coordinated associations' would suggest (3). Current administrative policies and

(1) For example, Hearn et al (1968), Bucher (1969), Olesen and Whittaker (1968)

(2) Both C W Mills (194) and Taylor et al (1973) see them arising out of the American philosophy of pragmatism.

(3) Gouldner (1968) has argued that much of recent labelling theory has presented an image of 'man on his back' as the perpetual hapless and passive victim of others actions. By extension it would be a mistake to characterise subordinates in organisations as lacking any influence, even if it is of a negative kind.

the philosophy of 'team work' require that both social workers and clinical psychologists be employed and work with psychiatrists. This is where a study of processes becomes relevant, for much of the time there may be no clear structure to the relationships to be found among such staff. This is not to say that there is no structure, but the participants may themselves only become aware of it, through certain processes that draw their attention to its existence.

There have been several studies of the mental health professions in the United States, but very few in Britain (1). Certainly, there have been none as yet, that have sought to explore the question of professionalisation from the point of view of all three of these occupations. In the literature on the professions, there are frequent references to the way that occupations that seek to be professions must win acknowledgement of their claims from their significant audiences. Thus the claims that the members of these occupations are making are posed against one another: Especial attention being placed on the psychiatrists' view of the lay occupations, in view of the former's power to grant or withold the means for the latter to fulfil their claims. Where this study also differs from many others, is the attempt to approach the study of professionalisation as a social process that can be comprehended through an analysis of the way that the members of the occupations in question experience, bring about or even hinder and oppose the professionalisation of their occupation. Occupational associations frequently make claims on behalf of their membership, and may engage in activities that are deemed necessary to make the occupation

(1) References will be given to these in subsequent chapters, the greater attention given to psychiatry by sociologists in the States, presumably reflects the different position of psychiatry in that country, vis Berger (1965).

appear more professional. However, the membership of such occupations often define their interests in very different terms, frequently viewing the process of becoming professional with distrust, if not apathy or opposition.

The study of professional 'processes' can thus be seen to require a socially grounded perspective, that takes as its starting point the need to situate the meaning given to being 'professional' with the participants themselves. Following Glaser and Strauss (1966), a broadly grounded theory approach has been taken to this study (1). This has meant that instead of starting with a set of hypotheses to test, as the logico-deductive method requires, this study was begun as an exploratory and essentially descriptive one. But as Gouldner (1971) has pointed out, no sociologist ever begins any study without prior assumptions, and thus it is necessary to point to the way certain assumptions shaped the direction of this study. This introductory chapter has in part been concerned with such an elucidation, and the subsequent 'introductory' chapters will also draw attention to the perspective that is being taken to the study of professionalisation and also that of psychiatric ideology. But Gouldner (1971) would appear to mean more than the intellectual and conceptual assumptions that are taken to any study, for he relates his remarks to those sociologists who obscure certain political positions behind their work. Bearing in mind the highly contentious nature of the treatment of mental illness and the various rivalries that have been identified between the staff being studies, the question 'whose side is one on' (Becker, 1967) might be put. During the field work it was apparent that many of the interviewees considered

(1) For more details on the methodology, see Notes on Methodology in the Appendices

the research to be against their interests, and this question was frequently, if less directly, posed by them. At the time this question was answered by reference to the neutrality of sociologists and their independence of either social work and psychology. This answer is still relevant, in so far as in the analysis of the interviews, and presentation of the data, the perspective that has been taken is that of outsider to all three occupations. But the problem is more complex than this, for as both Schatzman and Strauss (1966) and more recently Robertson (1969) have noted, the predominance of the psychiatric and to a lesser extent psychological approaches to understanding 'mental illness' have led to many sociologists adopting, sometimes explicitly but more often implicitly (as an assumption on Gouldner's sense), a 'psychiatric' frame of reference towards madness (1). This is clearly much more of a problem in studies of 'mental illness' but it led Schatzman and Strauss (1966) to declare that "It would be much more fruitful for sociology if more research were done <u>about</u> psychiatry than in it or for it" (emphasis added). In order that this study be <u>about</u> these occupations it is necessary at times, to relativise the various claims being made by the members of these occupations by posing them against one another, and further to be aware that an alternative structure, concepts and practices might have developed, if the medical profession had not an already established and institutionalised its influence over the treatment of mental patients. Thus for heuristic reasons, if for none other, it is necessary at times to 'suspend belief' in the validity of the claims being made, and instead to see them as being part of ideologies to be found in any situation where people seek to justify their actions, and

(1) This tendency is found particularly among studies of epidemiology of 'mental illness', on the functioning of mental hospitals and the social pathology approach to mental disorder. For critical reviews of such studies see Smith (1971), Robertson (1969).

reconcile their own situation with that of others around them.

The older professions may be able to point to their origins in the middle ages, but it was the industrial revolution and more particularly the development of the service sector within industrial economies that led to the proliferation of occupations seeking to win professional status for themselves. Such occupations tend to justify their existence by pointing to the need for their 'expertise' and the moral worthiness of their members, but the power of 'experts' who have established control over certain areas of human affairs, has not gone without criticism (1). Marx (1964) in a somewhat ironic passage has pointed to the way that "The criminal produces not only crimes but also criminal law and with it the professor who produces lectures on the criminal law ... The criminal moreover produces the whole of the police and of criminal justice, constables, judges, hangmen, juries, etc ..." (2). The same can be said of the madman, and this century has seen a proliferation of occupations that are dependent on the existence of madness, to provide a justification for their being. Once established there need be no fear of such occupations disappearing through lack of work, as they can claim to be the only people with the necessary expertise to detect and treat previously unidentified forms of deviance and distress. In recent years the right of certain professions to claim exclusive jurisdiction over the 'treatment of mental illness' has been increasingly challenged. One way of developing such a critique is through an analysis of the claims that such 'experts' make for themselves. This study aims to provide the beginnings of

(1) Illich (1973).

(2) Quoted by Hirst (1972).

such an analysis through an exploratory study of certain professional processes among three mental health occupations.

The Medical Board

CHAPTER 2

PROFESSIONALISATION AND THE MENTAL HEALTH OCCUPATIONS

Summary: This chapter contains a general discussion of the previous literature on professionalisation, with particular reference to the problems to be encountered when applying ideas from this literature to the mental health 'professions'. In particular, attention is directed towards the inadequacies of the functionalist and trait theorists' views of the professions. The weaknesses of these perspectives being especially apparent when applied to the mental health occupations. After a consideration of certain general features of the 'professionalisation' of the three occupations being studied, an alternative perspective is suggested. Such a perspective requires that more attention be paid to the ideologies that permeate the process of professionalisation.

> "... a dominant profession stands in an entirely different structural relationship to the division of labour than does a subordinate profession. To ignore that difference is to ignore something major. One might call many occupations 'professions' if one chooses, but there is difference between the dominant profession and the others. In essence the difference reflects the existence of a hierarchy of institutionalised expertise" (Freidson, 1971, p.137) (emphasis as in original)

This quotation provides a useful starting point from which to approach the study of professionalisation in general, and in the mental health field in particular. The literature on the professions and professionalisation is a vast one and consequently any reference to it must be highly selective (1).

(1) Ben David (1963) and Moore (1970) both list nearly 700 references each. As well as the general reviews of the literature provided by these two writers, there have been others by Elliott (1972) and also Johnson (1972).

This chapter will aim at providing a brief review of some of the main features of this literature, in order to demonstrate how certain ideas have influenced the course of this study. After that there will be a consideration of the extent and nature of professionalisation among the mental health occupations. The general problem of how to approach the study of professionalisation will then be raised again, in view of the particular features of the situation facing the mental health 'professions'.

There are many different definitions of the meaning of the term profession, and it will be the task of this chapter to indicate how this term will be used in this study. Jamous and Peloille (1970) have suggested that this term be abandoned altogether in view of the confusion that surrounds its use. This course of action is not being recommended in this study, because it is believed that the 'professionalism' represents a distinct form of occupational control. In their attempts to establish control over certain knowledge and skills, the professions may be no different to any other occupation, but the form through which such control is institutionalised represents a distinct form of social organisation. Professionalisation is thus being viewed as a continuous process in which the established and emergent 'professions' seek to defend or extend their claimed occupational mandates.

The sociological interest in the professions goes back to the early part of this century, when the main question being asked about them was, where do they stand in the class structure? (1) By the 1930's, however,

(1) The most notable sociologist being Durkheim (1964), but also Marshall (1939) and later Parsons (1939) were concerned with this question.

the question had become much more one of trying to establish the 'essence' of a profession (1). Many sociologists have continued work in this vein ever since, although differing as to the conclusions that they have drawn. In a recent review of the literature on this question, Millerson (1964) was moved to remark that, "Of the dozens of writers on this subject few seem able to agree on the real determinates of professional status" (2). In a further publication, Millerson (1968) listed 23 elements that had been included in the definitions of a profession by some 21 authors on the subject. With this problem in mind it is hardly surprising that E. C. Hughes commented, "In my own studies I passed from the false question 'is this occupation a profession?, to the more fundamental one, 'what are the circumstances in which people in an occupation attempt to turn it into a profession, and themselves into professional people'" (quoted in Volmer and Mills, 1966, p.V).

However, even if E. C. Hughes has abandoned the quest for criteria with which to judge whether certain occupations are professions or not, many other sociologists have continued trying to identify the core 'characteristics' or 'traits' of a profession. Perhaps the most frequently cited example being that of Greenwood (1957) (3). After

(1) The classic work in this area being that by Carr-Saunders and Wilson (1933).

(2) Goode (1969) would appear to disagree, he states that, "if one extracts from the most commonly cited definitions all the items which characterise a profession ... a commendable unanimity is disclosed; there are no contradictions and the only differences are those of ommission" (p.903).

(3) The main elements being; A basis of systematic theory, based on rationality and self-criticism as opposed to traditionalism, 2) Professional authority, derived from 1) and located in the functional specificity of his knowledge over the layman's ignorance, 3) the sanction of the community - ie the power to licence its members, and the privilege of confidentiality over dealings with clients, 4) A regulative code of ethics, both formal and informal, and 5) A professional culture derived from the values of service, the norms governing action and symbols of the occupation.

listing various attributes, he then suggests that the different elements should be placed along a continuum, so that various occupations can be considered to be more or less professional. This continuum idea has received much support from other contributors such as Pavalko (1971) and Elliott (1972) (1). Although not always sharing the same theoretical perspective, many of the trait theorists have drawn a rather similar picture of the professions, to that presented by certain functionalist writers. Quite apart from the work of Parsons (1951, 1968) this approach has been explicitly applied to the professions by Barber (1963), and implicitly applied by Moore (1970). Where the functionalists differ from the trait theorists, is that after listing the attributes of a profession, they then attempt to show how these attributes serve and are functional for the wider social system. Parsons (1951) for example, has argued that a professional is a person recruited and licenced on the basis of his technical competence according to certain universalistic criteria, rather than any ascribed social characteristics or other particularistic standards. His privileges and standing stem from his adherence to certain ethical codes that arise so as to restrict the professionals involvement with clients, to those matters over which he has specific knowledge, and can act in a neutral manner. In an advanced industrial society it is believed that specialisation is both inevitable and necessary, thus specialists are placed in a particular relationship towards both the State, and their clients. It is assumed that while the knowledge should be applied in the 'communities interests', only the professionals can decide on its

(1) A variant of the continuum idea is the suggestion that there are a series of 'stages' that occupations must go through in order to become professions. Both Willensky (1964) and Caplow (1954) have developed outlines of such stages.

applications and the possible implications of their practices. Further the functionalists argue that while the State may recognise or revoke the rights of certain professions to control the application of this knowledge, it will not intervene in the affairs of that profession. Thus the functionalist perspective on the professions assumes that they represent, "that sector of the cultural system where the primacy of rationality is presumed" (Parsons, 1968). Legitimacy and community sanction is therefore accorded to various occupations in such a way that a 'natural' ordering occurs, with the most 'functionally necessary' occupations being granted the greatest power and prestige.

The main weaknesses in functionalist thinking are immediately evident in the above summary of the application of this perspective to the professions (1). Johnson (1972) has presented the most detailed criticism of both the trait and functionalist theories of the professions in recent years. He suggests that not only have such theorists simply adopted the professions' own views of themselves and their role in society, but more seriously, have presented both a-theoretical and a-historical perspective, on 'the peculiar institutionalised form of occupational control', that he takes the professions to represent. He charges Parsons, for example, with having assumed an intimate relationship between the professions and the institutions of science, such that rationality dominates not only the content of professional practice, but also colleague and client relations. According to Johnson, Parsons has eliminated from consideration the power relationships within a profession. These

(1) The debate on the functionalist perspective on stratification is particularly relevant to the professions, as the latter are the group in society that deserves high status, according to this perspective. See Davis and Moore (1945), Tumin (1953). The most frequent criticisms levelled against functionalism are those of tautology, conservatism and reification - see Cohen (1969).

relations, he contends enable dominant cliques to impose role definitions on the profession that may bear little relation to the 'rational application of knowledge'. Further, Johnson contends that actual relations with clients can be influenced by many considerations that suggest a different meaning to the concepts of 'affective neutrality' and 'professional authority', than that suggested by both the trait and functionalist theorists (1) (2). Rueschmeyer (1964) has also questioned the assumption made by functionalist writers on the professions that there are 'central values' that are shared equally by all sections of society. He points to the quite different values attached to the 'law', 'justice' and 'responsibility' by not only members of the legal profession, but also among the general population. A similar point can be made about the differing conceptions of 'health' and 'illness' held by doctors and patients (3). While the varied access of different social classes to the services of most professionals points to the way the actions of professionals are not governed solely by their conceptions of the clients' interests, but rather by such mediating factors as the class position of the client (4). Traditionally many studies of professionalisation

(1) This point has been made by Freidson (1970), and Freidson and Rhea (1963) and can be substantiated by reference to much of the work on doctor-patient interaction, eg Stimson and Webb (1974), Bloor (1974).

(2) Gill and Horobin (1972) have also noted the limitations placed on medical practice by the State in Britain.

(3) See for example, Jaco (1958) and Mechanic (1968).

(4) Myers and Schaffer (1954), Myers and Roberts (1959), Siegal (1962) and Hollingshead and Redlich (1958).

have either explicitly or implicitly adopted the functionalist or trait approach but as Johnson has pointed out,

> "... one of the underlying assumptions of the approach is that it is the inherent qualities of an occupational activity which autonomously determine the way in which the institutionalised forms of control will develop, neglecting any reference to such factors as the prior existence of powerful and entrenched occupational groups, or the extent to which governments or academic institutions may impose their own definitions on the organisation and content of practice" (p.30).

Bearing in mind the various problems that have been identified in the study of the professions in general, it is now relevant to turn to the particular question of professionalisation among the mental health occupations.

The Mental Health Occupations

In Chapter 4 there will be a more detailed consideration of certain features of the history and current position of psychiatry, clinical psychology and social work. The more immediate task is to consider various studies that have been concerned with professionalisation among these occupations. As noted in Chapter 1, there is a problem in so far as most of the writing in this area has come from the United States (1). However, it still has some relevance, and it played some part in the development of the ideas that led to this study. Quite apart from the specific studies on the mental health professions, there have been other writers such as Goode, who have considered these occupations in their more general writings (2).

Goode (1969) has suggested that the four person professions of the

(1) There is a discussion of some of these problems in Chapter 3, pp. 47-50.

(2) The best known studies have been by Zander et al (1957), Rushings (1964), Strauss et al (1964), Henry et al (1971). Certain findings from these, and other studies, will be referred to at various points in this study.

Law, Medicine, the Ministry and University Teaching should be taken as models of the 'true' professions. From a study of these occupations he has suggested that there are two central generating qualities of a profession; a basic body of abstract knowledge and the ideal of service. Leaving aside the criticisms that can be levelled against this approach to the study of the professions, this formulation does draw attention to the need to evaluate the nature of the abstract knowledge to be applied in the treatment of mental illness, and secondly, how far the service ideal can be upheld by the mental health occupations. Goode himself has suggested that both clinical psychology and social work should be regarded as occupations that are likely to become professions, as both embody the service ideal, and further both are developing bodies of abstract knowledge. Social work taking its knowledge from Sociology and Psychology, while clinical psychology has its own abstract knowledge that is being developed within universities and thus outside the control of medicine. However, in an earlier article he has drawn attention to the problems that both of these occupations, and particularly clinical psychology, face when confronted with the organised opposition of the medical profession (1). This point will be considered further on, but first attention must be drawn to the problem of identifying the 'abstract body of knowledge' to be applied by psychiatrists or either of the other two occupations.

The importance of having an abstract body of knowledge stems from the control this gives the profession over the application of its skills, a control that is granted to the professional 'community' by the wider community once it is recognised that only that profession has the

(1) Goode (1960).

expertise to solve certain problems (Goode, 1957, 1969). However, when the problem is mental illness, not only is it apparent that the 'community' recognises a wide range of 'specialists' as having something to contribute, but that many 'unqualified' and fringe practitioners are also turned to for advice and help (1). Further, it is also apparent that not only is there more than one profession involved in this area, but that within these professions there are segments, factions and rival groupings that often have little more in common than a claimed interest in the treatment of mental illness (2). As many commentators on psychiatry have pointed out, there is no body of principles that is common to all practitioners, and even the apparently established diagnostic categories have recently been increasingly attacked (3). The problem remains then of accounting for the current institutional dominance of the medical specialty of psychiatry over the treatment of many conditions that are acknowledged to have few, if any, medical features. While it may be accepted that medical knowledge has considerable bearing on a few cases, and a little bearing on a larger number, it can hardly be argued as the functionalist model of professionalisation would suggest, that psychiatry, any more than the other rival occupations, has won unequivocal recognition for its expertise from the general public (4). The treatment of mental disturbance, throughout the ages

(1) For a detailed study of the variety of alternative sources of help that patients often turn to before consulting the established professions see Kadushin (1968). Further, it appears that the general public does not 'recognise' or understand the differences between psychiatrists, psychologists and psychiatric social workers Nunnally and Kitross, 1958), also Rogow (1970).

(2) Bucher and Strauss (1961) have drawn attention to this process among pathologists. The point is even more pertinent when applied to psychiatry, the recent history of the factionalism within psychoanalysis providing the clearest example of this (see Harper, 1959).

(3) See quote by Lewis given on p.2 (Chapter 1).

(4) The same can be said of social workers as a study by Mayer and Timms (1970) has shown.

has always raised religious, political and moral questions, for this reason alone it seems improbable that a body of knowledge will ever be developed by any occupation, that will command universal acknowledgement and acceptance (1).

A further problem that is raised when attempting to identify the nature of the expertise being claimed by the mental health occupations, is that many practitioners claim their therapeutic abilities derive not so much from the application of certain techniques, but more from the way in which they 'relate' with the patient. Halmos (1965) has termed this the 'faith of counsellors' and he has shown how many counsellors appear to reject any suggestion that their work be regarded as 'scientific' or 'technical'. At a more general level Jamous and Peloille (1970) have developed what they term an Indeterminacy/Technicality Ratio, in order to assess how far the members of an occupation claim that their knowledge is of a 'technical' nature and thus can be learnt from manuals and textbooks or transmitted directly through apprenticeship, as opposed to being of a 'private' and tacit kind, such that it is the personal property of the practitioner. Such knowledge cannot be taught by formal means but only by example and experience in such a way that it is internalised and becomes defined as personal qualities or 'virtualities', to use Jamous and Peloille's term. They suggest the professions are occupations that are high on the indeterminacy scale, and in their analysis of the French Medical Corps, they note that in the past it was dominated by a group whose ideology stressed the indeterminate nature of their skills

(1) The same applies to physical health, as well as to the activities of other professions such as Law, but the situation is clearest when considering mental disturbance.

and the virtualities of the practitioner. However, they suggest that in an ensuing struggle with emerging sections that stressed the technical and scientific basis of medical practice, the former dominant group were defeated. Although such a victory might be seen as a victory for 'science', Jamous and Peloille are primarily concerned to draw attention to the way that, "... the definitions and functions of an activity are by reasons of technical change, social struggles and divisions, perpetually objects of confrontation and conflict" (p.118).

The relevance of Jamous and Peloille's work for this study is the attention they have given to problem of identifying the nature of skills and knowledge, or in other words, the expertise that members of occupations possess. But whereas Jamous and Peloille seek to develop and measure such 'objective' differences, the real value of the Indeterminacy/Technicality ratio lies in pointing to the way certain sections within an occupation, or an occupation in competition with others, may seek to defend their dominance through reference to their generalised and indeterminate abilities (1). The treatment of mental illness, although it involves certain technical abilities, would appear to be based more on the indeterminate and personal qualities of the therapist, as Halmos (1965) has pointed out. This question will be taken up again in Chapter 4, while in Chapter 3 attention will be drawn to the need to consider the definitions that the members of different occupations make of their expertise, as important elements in the ideologies to be found among them.

(1) Other commentators on the professions have also noted the way 'generalists' and the 'all rounders' have often been granted a higher status, both within occupations and by outsiders. See, for example, Carr-Saunders and Wilson (1933) comments on 'generalist' social workers concerned with 'social' issues. Further on the criticism of Atkinson et al (1972) to Jamous and Peloille will be noted.

The other core characteristic that Goode (1969) has drawn attention to is the so-called 'collectivity orientation' or the ideal of service. Goode is not alone in attaching significance to this, as Flexner (1915), Marshall (1939) and more recently Elliott (1972) have all drawn attention to it. Quite apart from the general claim that professions are primarily providing a service, rather than seeking to make money as a businessman might; the ideal of service allegedly means that the technical solutions the professional person arrives at will be based on the client's needs rather than those of the professional or some third party. As Goode has pointed out, such professionals are expected to display self-sacrifice in the interests of their clients, if not all the time, then at least occasionally. It has also been suggested that some occupations require greater trust and personal 'involvement' on the part of the practitioner. Goode (1969) has, for example, suggested that the four established 'person professions' can be set above other occupations for this reason.

Halmos (1970) has drawn a somewhat similar distinction and talks of the 'personal service professions' which he believes all share a common counselling ideology that, "advocates concern, sympathy and even affection for those who are to be helped" (p.14). For Halmos, as for many other writers, the fact of having another person as the object of the professional activity poses particular problems. Goode has suggested that where the possibility for exploitation of the client as a person is greatest, then there will also be the greatest need for internalised norms of professional conduct. He suggests that the situation of the psychotherapists illustrates this point. The emotional content of the relationship and the vulnerability of both client and therapist generate the need for professional autonomy and trust. As E. C. Hughes (1958) has observed, those occupations that require 'guilty knowledge' must

be granted the rights of confidentiality, and assurance must be given to the client that this knowledge will not be used against him (1).

Consideration is being given to this question of the ideal of service because all three occupations being studied are usually considered to embody this ideal. Indeed, those writers who have designated social work as a semi-profession are quick to point out how it is higher on the service ideal 'scale' than many more professional occupations (Toren, 1969) (2). Psychiatry, by association with medicine, is assumed to embody the same values and clinical psychology, where it involves psychotherapy, is also characterised in the same way. Further, it is claimed that these occupations, in being concerned with the health and welfare of their clients before all else, are non-judgemental and free of moral bias when considering their client's behaviour. An important element in the occupational mandates claimed by all three of these mental health professions has been the contention that they are not holding their clients to be morally responsible for their behaviour, but instead are only concerned to understand and treat. The dominance of medical terminology and concepts throughout the mental health professions lends credence to such claims, for they have the aura of being morally neutral while at the same time appealing to the widely supported sentiments of 'health', 'treatment' and 'cure'. These points need to be made for they are very powerful and evocative elements in the general

(1) NB: Hughes' (1958) other observation about the 'danger mandate', "I suppose this ultimate licence is greatest when the people who exercise it - being guardians of precious things - are in a position to do great damage" (p.81).

(2) Freidson (1970, p.174) has reported a study in the United States that shows that social work students have a higher service orientation than medical students.

ideology that surrounds the personal service occupations.

Thus, if one was to follow some of the recent writers upon professionalisation then all three of the occupations being considered might be taken to embody this service ideal. However, the theories of the academics and the claims of the practitioners have not gone without challenge. Goffman (1968) has observed that the service complex is typically held to involve both the free choice of the client in entering a relationship with the practitioner, and also the freedom of the server to exercise his judgement solely in accordance with the principles of his profession. But the situation of the mental patient is one in which these conditions are rarely fulfilled, for as Goffman points out, there is a triad of server, client and community such that,

> "... the more the server is concerned with giving good service and the more his own profession is given a public mandate to control him, the more he is likely to be accorded the task of maintaining community standards which at times will not be in the interest of the particular client" (p.296).

Goffman then embarks upon an extensive analysis of the myriad ways in which the conditions under which many patients are kept in mental hospitals only fits the service at an ideological level. This ideology finds expression in the medical rhetoric of the staff that serves to obscure the fact that their primary task is mainly one of controlling and containing disorderly behaviour (1).

One problem of Goffman's work is that it is based on studies of mental patients who were all being kept under compulsory detention. For it could be argued that as only a small proportion of mental patients and the clients of social workers are the subjects of various legal

(1) As he expresses it, "Mental hospitals institutionalise a kind of grotesque of the service relationship" (p.321).

orders that they have freely chosen to seek the services of these professions. Such arguments have been advanced by psychiatrists in recent years, when talking about the changed status of their speciality. However, the question is not simply one of whether or not the patient or client are 'voluntary' or 'compulsory' when seeing such a professional, but rather whether they had any choice to find an alternative solution to their problems. The structure of referrals in the health and welfare services often leaves the 'voluntary' client with little option but to submit to the ministrations of those who claim to serve them. Once inside the mental hospital the patient is likely to find his civil liberties and other rights variously infringed and denied, 'for his own good' (1). In recent years psychiatrists, and by association, clinical psychologists, and social workers, have been accused of acting, not in the interests of their clients, but rather as 'agents of social control' (2).

At the centre of this criticism has been the accusation, made by Wooton (1959) and repeated by many others, that moral judgements, not medical diagnoses, lie at the heart of psychiatry and related activities. Wooton extends her criticism to social workers and casework, as she puts it, "Just as in psychotherapy itself moral judgements may lie

(1) Szasz (1961, 1963, 1965) has become the best known critic of this aspect of psychiatry. More than anyone else in recent years he has popularised the view that psychiatry is a pseudo scientific activity that is more concerned with enforcing conformity than anything else. Teeling Smith (1973) has documented the number of patients under detention and locked wards, and has shown it to be more than is generally believed. See also Harrison (1974).

(2) Maddison (1973) has recently analysed the role of university psychiatrists in this light. This view has been articulated most consistently by the anti-psychiatrists such as Cooper (1967), Laing (1965, 1971), Esterson (1970) and in such works as that by Agel (1971).

concealed in what appears to be the neutral science of medicine" (p.283). For Wooton and other critics of social work, casework is seen as the imposition of middle class values on a working class population, whose problems could be more appropriately dealt with through financial assistance (1). The coercive nature of the relationship that all such personal service professions have with their clients at times, arises from the statutory duties that they have to perform. But even those clients who have ostensibly become the 'voluntary' client or patient of such professionals, have often been 'forced' into seeking assistance, either through a process of referral from other agencies or dire material need. Sociologists tend to regard the latent social control functions of these professions as being their most important characteristic. In recent years, the more dissident elements within these professions have also attacked the way they can only act in the 'interests of their clients', if such action does not disrupt the status quo (2). However, so strong is the 'service' ideology that relationship between server and served is rarely described as coercive in the literature of these occupations (3).

In view of the criticisms that were levelled against the functionalist and trait views of the professions in the early part of this chapter, this discussion of the problem of judging the mental health professions from these perspectives, may seem an unnecessary digression. However,

(1) Sinfield (1969) and Leonard (1968) have also made this point.

(2) Halleck (1968), Leiffer (1969), Steadman (1972), Greenley (1972) have drawn attention to this feature of psychiatry, while Epstein (1970, 1973) as also noted it in connection with social work. Also the radical magazine of red rat and case con have carried several articles on this theme.

(3) An exception being Leighton (1967) who has pointed to what he terms the 'myth of self-determination' in casework.

by pointing to the way that none of the three occupations can at present claim to have a proven body of knowledge, and secondly by suggesting that they do not always uphold the service ideal, the inadequacy of these approaches which adopt the professions own view of themselves can be further illustrated.

In Chapter 4, there will be a more detailed consideration of the 'professionalisation' of each of the three occupations, and it will be observed that all three claim to carry out psychotherapy. Indeed, in the various studies that have been carried out on the 'psychiatric professions the point that is continually made is that the area of greatest controversy and conflict, is over the question of who does psychotherapy. Smith (1957) has commented on the way the

> "... still emergent specialty of psychiatry meets the professionalising drives of psychiatric social work and clinical psychology and the competition of other non-medical psychotherapists. The resultant of this meeting has been conflict over professional status and function. In the area of overlap psychiatry, the medical outsider stays the powerful role of medical specialty confronting non-medical groups. Its status, and the power of organised medicine, may operate to maintain the continued subordination of non-medical psychotherapeutic groups (p. 315)

As noted previously, most of the literature on the psychiatric professions relates to the American situation, where it would appear Freudian ideas and practices have been much more widely accepted than in the United Kingdom (1). Certainly the practice of 'psychotherapy' would appear to have been much more widespread (2). Henry et al (1971), for example, have claimed that a 'fifth profession' of psychotherapists

(1) Berger (1965) has provided a very illuminating account of the influence of psychoanalysis on American culture. More specifically, Rogow (1970) has drawn attention to the dominance of psychoanalysis and psychotherapy as major forms of therapy practiced in the US, although he believes this to be declining.

(2) Halmos (1965) has estimated that the US has three and a half times as many counsellors per head of the population as the UK (p.47).

should be created out of a merger between the four existing professions of psychiatry, psychoanalysis, psychiatric social work and clinical psychology. Amongst other things in common, they note that 74% of their sample of practitioners, taken from the above professions had all undergone, or were currently undergoing, some form of therapy.

Whether or not some possible merger would ever be contemplated, there is abundant evidence of the conflict that has occurred between these groups in the United States. This conflict would not appear to be simply over qualifications to carry out therapy. For the private practice basis of psychiatry, and especially psychotherapy, in the US, has meant that lay groups have often threatened the economic interests of the medical profession (1). Ausubel (1956) has also suggested that the conflict is particularly evident because of the threat the non-medical psychotherapists pose to the incomes of psychiatrists. Goode (1960) has recorded the opposition of the American Psychiatric Association to State licencing schemes for clinical psychologists, and has suggested that it was for similar reasons. In a later work (1969) he has suggested that social workers have not encountered opposition from psychiatrists to their professionalising ambitions, largely because they are not in competition for clients.

These American studies are being referred to because at the start of this study they were one of the main sources of reference on the psychiatric professions. They consequently influenced the initial ideas from which this study developed. Quite apart from the further qualifications to be made about the relevance of cross cultural comparisons in Chapter 3,

(1) Davidson (1956) has given details of this, and has demonstrated how the major part of all psychiatrists' income comes from private practice.

it will be suggested in Chapter 4 that while psychiatrists, clinical psychologists and social workers in Britain have claimed to carry out 'psychotherapy', it has traditionally not been the major activity of any of these occupations. For this reason there may not have been as much conflict over who should carry it out as there has been in the United States (1).

Conclusions

In Chapter 4 it is suggested that the history of each of the three occupations cannot be understood apart from that of the others. In particular, the prior dominance of the medical profession in the main institutional arena in which these occupations come into contact has necessarily affected the current structure of interprofessional relationships. This fact must not be lost sight of, for it is possible to conceive of an alternative structure having arisen. An alternative structure of staff relations would have likely consequences on the way patients are regarded and looked after, and thus an examination of the ways in which the current structure is maintained can be seen to have a certain value, for this reason, if none other. The problem remains, however, of how to approach the study of professionalisation among the mental health occupations. In the quotation given at the start of this chapter, Freidson asserts that the 'dominant profession stands in an entirely different structural relationship to the division of labour than does the subordinate one'. If this is taken as a starting point, then the question becomes one of analysing the nature of the control that the dominant profession has over the division of labour and the

(1) This question is also raised again in Chapter 9, as is the problem of arriving at any definition of the term psychotherapy.

'hierarchy of institutionalised expertise'. For as Freidson goes on to point out,

> "... if the substance of (a profession's) knowledge is known to and performed by others, the occupation cannot be completely autonomous, because those others can legitimately criticise and otherwise evaluate the way it carries out its work" (p.134).

This consideration raises the question of the nature of this knowledge and expertise and the way in which those in dominant positions, and likewise those in subordinate positions, develop ideologies that either contain defences of their position or calls for it to be changed. For as Atkinson et al (1972) have commented in a paper that examines the value of Jamous and Peloille's work;

> "Professional process is characterized by continual interaction between the constituent groups that make up a 'profession', they are not stable, nor consistent, but rather shift and reform over time. Groups can be identified at any particular time by an ideology, a set of values, beliefs, assumptions and ideas that inform their understanding of the work they do, the characteristics of themselves and others and the rhetoric of their debates. Such ideologies are not arbitrary, but rather are articulated around an important set of dimensions one of the most crucial of which is indeterminacy/technicality; others that are important include superiority/inferiority, and autonomy/dependance. Running through these ideologies and linking them at particular points on the various dimensions that characterise them is the notion of <u>control</u>, and it is control that we see as the touchstone to understanding professional process" (pp.14-15).

While an analysis of ideology on its own cannot be taken as sufficient in itself to account for this control, it can at least draw attention to certain features of the current structure of relations between these three occupations. By concentrating on the existing levels of consciousness and the way the various groups, and sub-groups within these occupations view themselves and one another, it may be possible to establish how far, if at all, the aspiring professions of social work and clinical psychology have gained control, or will be able to gain control over the application of their own knowledge. Further than that,

such an analysis may provide the means to develop an understanding of the way in which an established profession is able to maintain its control, in situations where it appears that, ' the substance of its knowledge is known to and performed by others'. It is not sufficient to assert, as Freidson does in the passage quoted at the start of this chapter, that such dominance stems from the prior existence of an 'institutionalised hierarchy of expertise', without examining the nature of that expertise. For the claims and the counter claims that are made about expertise usually involve assumptions about the nature of the authority structure, the appropriate division of labour, and the relationship of one person's work to another's.

In the following chapter, the question of ideology will be considered in more detail. There is an extensive literature on psychiatric ideologies and it is necessary to draw attention to the way that this study differs from previous studies. The bearing that this literature has on the issues raised in this chapter will be noted, while in Chapter 4 the question of professionalisation will be taken up again when examining the past development and present position of the occupations of psychiatry, 'psychiatric' social work, and clinical psychology.

CHAPTER 3

PSYCHIATRIC IDEOLOGIES AND THEIR BEARING ON PROFESSIONALISATION

Summary: This chapter presents a review of the past studies on psychiatric ideology. It begins with a discussion of the need to develop a socially grounded approach to the study of ideology that can encompass mundane assumptions as well as theoretical ideas. Recent studies of psychiatric ideologies are then reviewed in this light. While such studies have drawn attention to an important aspect of the treatment of mental illness, it is suggested that they display certain methodological weaknesses, as well as being 'culture bound'. Most of the studies on the psychiatric professions and ideologies have been carried out in the United States, and thus the problem that this raises when considering the situation in Britain are noted. Finally attention is drawn to the bearing of the study of ideology on the study of professionalisation.

> "... when studying ideologies the methodological pitfall that one is likely to stumble into is precisely that of missing the fading out, the breaking away and the coalescence of beliefs each of which signifies the potential emergence of new ideologies. A methodology that relies solely or primarily upon questionnaire data is very apt to miss these emergents, or if it catches aspects of them, it does not always give the researcher adequate clues for insightful interpretation. To grasp these clues the researcher had best also speak at great length with the ideologists as well as studying them when they talk of and act out their beliefs." Strauss et al (1964) (p.9).

In the previous chapter, it was suggested that one possible way of approaching the study of professionalisation was to examine the ideologies that emerge around and give expression to this process. Further, it was argued that an important component of such ideologies was the beliefs that arose to justify the control professions seek to exert over the application of the knowledge and techniques they consider

to be their own. The argument that was put forward would apply to many different forms of occupational control, not simply to those in the mental health field (1). However, there have been many suggestions that the mental health field provides the best example of developed and identifiable ideologies. Marx (1969) has suggested that the field of mental illness provides the best illustration of "ideologies providing guide lines and rationales for professional behaviour" (p.77) (2). Schatzman and Strauss (1966) have suggested that a study of psychiatric ideology be one of the substantive areas of a sociology of psychiatry. Accepting that there is an established literature on 'psychiatric ideologies', and this is alleged to have a bearing on the question of professionalisation among the mental health occupations, it is necessary to consider certain features of these previous studies. But before doing that a few general points should be made about the meaning that is being attached to the term ideology.

The term ideology is one that has been freely used by sociologists in a variety of different ways and contexts. Birnbaum (1960) has suggested that "the study of ideology moreover is at the intersection of the empirical and philosophical components of our discipline" (p.91). In view of the meta theoretical and philosophical origins of the debate on the nature of ideology, it might appear misplaced to invest the concept with some micro-empirical meaning (3). However, as Birnbaum shows through his review of the literature, there is already an established tradition

(1) There is an extensive literature on various forms of occupational ideology. This is summarised by Taylor (1968). See, for example, Dibble (1962) and Elliott (1973) study of the different ideologies of doctors working on a cancer unit.

(2) Johnson (1972), Elliott (1972) also refer to this area as providing good examples of such ideologies.

(3) The 'misuse' of the term alienation in empirical studies being a parallel case - see Horton (1965).

of attempting to relate ideas and beliefs to certain aspects of the social structure. At the outset of this review he suggests that,

> "... for this essay, it suffices to assume that ideologies appear, wherever systematic factual assertions about society contain (usually by implication) evaluations of the distribution of power in the societies in which these assertions are developed and propagated. We may accept that a group generally accepts a view of society that is consonant with its interests; we need not think that ideologies are consciously fashioned to serve these interests or the groups are incapable of acting upon beliefs that appear to contradict these interests. Ideological elements following this definition, are also found in aesthetic and moral statements about the human situation." (p.91).

If the term 'social situation' is substituted for 'society' the value of this definition for use in micro situations becomes more apparent. Further, Birnbaum's suggestion that ideologies 'are not consciously fashioned' serves as an important reminder to explore precisely those 'common sense' and 'taken for granted' beliefs that are often important, if difficult to identify, elements of ideologies. Indeed, since Birnbaum wrote his article, the study of ideology has taken a dramatic turn in this direction. The recent rise of phenomenology and ethnomethodology has led to a series of studies of the 'ground rules', the 'taken for granted' assumptions, and the 'everyday typifications', that make up the knowledge that ordinary people have of their daily lives (1). While this approach has provided a useful attempt to draw the attention of sociologists to the way society is constituted in every day life, and has, in particular, revealed the inadequacies of many allegedly 'objective' studies, it has also failed to deal adequately with such 'reifications' as authority relations (2).

(1) There are many recent reviews of the literature in this area. For example Turner (1974), Gummer (1971), Dreitzel (1971), Filmer et al (1971).

(2) See Gouldner (1971) and Taylor et al (1973) who have presented critiques of this theoretical approach.

Some phenomenological writers have, however, sought to analyse the way certain definitions of reality become attached to certain power interests, and further how the powerful are able to enforce their definitions of reality, over possible rival ones (1). Many of these studies have a bearing on the way ideologies develop in occupational contexts. The work of Scheff (1966), Sudnow (1967) and Cicourel and Kitsuse (1963) for example, has revealed how tacit rules and strategies develop that enable the practitioner to gain control over certain problematic situations. These ground rules of daily work life are somewhat similar to the beliefs, assumptions and assertions that have been found in the earlier studies of occupational cultures and the world of work, undertaken by E. C. Hughes and other more symbolic interactionist members of the Neo Chicago School (2). A common theme that can be detected in many of these studies has been the concern to show how the beliefs that members of society hold about their own role and relationships within society, have consequences upon that society. Following W. I. Thomas's oft quoted dictum, it is generally accepted that 'definitions of a situation are real in their consequences', however, whereas the phenomenologists assert that the 'reality' of society only exists in the minds of the members of society, the symbolic interactionists appear to accept that there is a structure to relationships, even if the management of these relationships is highly problematic and surrounded with uncertainty (3).

(1) Berger and Luckman (1967) for example have talked of "when a particular definition of reality becomes attached to a concrete power interest, it may be called an ideology" (p.141).

(2) Examples of the perspective being provided by Hughes (1958, 1970), Becker (1961, 1963, 1968), Gold (1952), Weinburg and Aron (1952) and summarised in Krausse (1971).

(3) Goffman (1959, 1963, 1968, 1970) has provided some of the best examples of problems of managing everyday interaction.

If it is accepted that it is relevant to consider the way certain assumptions inform a person's understanding of their own position in the various social situations that they occupy, then such assumptions can be seen to be important components of belief systems. For the purposes of this study, the term ideology will be taken to refer to the wide range of beliefs, assumptions and assertions that may or may not include reference to theoretical ideas, but which appear to reflect the attempts of people to make sense of their own situations, and the way they reconcile it, with that of others around them. Contained within such ideologies will be reflections of the way people make sense of the social structure that they inhabit. Thus while some ideologies might be expected to seek to legitimise dominance, there will be others that reconcile subordination. The term ideology is an overworked one, but no other term conveys as well as it does, the way that 'reality' is perceived and distorted by the most 'neutral' of observers, let alone by those committed to the positions they occupy within that reality.

As the following review of the literature on psychiatric ideologies suggests, previous studies have taken as their primary focus, the identifiable differences of opinion over the aetiology and treatment of mental illness. While there may be evidence for such differences, it will be argued that an unnecessarily narrow view has been taken of the possible range of ideologies to be discerned among mental health professionals.

Past studies on psychiatric ideologies

With a few exceptions, nearly all the studies to be referred to have been carried out in the United States. The problems that this raises will be considered further on, but first it is necessary to consider some of the main points to emerge from these studies.

The first systematic study of psychiatric ideology would appear to be that of Gilbert and Levinson in 1956. In their initial study they developed what they termed a Custodial Mental Illness Ideology Scale (CMI for short), and applied it along with various personality inventories. Their aim was to see whether there was a relationship between 'custodial' as opposed to 'humanistic' attitudes towards mental illness, and personality structure of various members of staff. Using the same scale with some additions, Carstairs and Heron (1957) have done similar work in this country. Caine and Smail (1966, 1969) have also done a series of studies that have aimed at identifying the type of staff who have 'therapeutic' personalities and attitudes towards patients. While these scales have also been applied to more senior staff, it is significant that it is usually the personalities of the lower order staff, such as the nurses or aides that are defined as being the problem (1). It could be argued, and it has been borne out by the findings of these studies, that 'custodialism' is likely to be created by the institutional pressures and contingencies acting on certain staff at the bottom of the hierarchy (2).

Although there were other interests as well, the initial focus of studies on psychiatric ideology has been on its relationship with personality. As Gilbert and Levinson (1956) state "an individual's orientation towards mental illness is an intrinsic part of his general approach to life problems and is related to deeper lying personality

(1) Prior to the more systematic work of Gilbert and Levinson and others, Middleton (1949, 1953) had noted this problem. Stanton and Schwartz (1954) and Caudill (1958) also concentrated on the attitudes of the aides in their studies.

(2) Carstairs, for example, found that group CMI scores correlated more closely with educational levels than anything else. In other words the doctors had the lowest CMI scores, that is they were the least custodial. Gilbert and Levinson also note how the "units having the most custodial policy requirements had the most custodial moral ideologies and the most authoritarian personalities" (p.270).

dynamics" (p.267). In a subsequent depth study of ten male aides which involved the use of the Thematic Apperception Test (Mental Illness), Pine and Levinson (1957) distingush two types of aide, the custodial and the humanitarian, and then suggested that the aides own childhood experiences affected their handling of patients (1). In a further study in which the CMI scale was used, Gilbert and Levinson (1957b) also attempted to relate the aides' ideology, notably with their personality, but also with their actual role performance. However, while a 'remarkable correspondence' was found among the female aides, it appeared that on the male side, that "Ideology was a more proximate determinant of behaviour than is personality" (p.206).

However, despite this finding, there has been a continuing stream of studies by both psychologists and psychiatrists, that have been concerned with relating personality differences to ideologists. The early interest in 'custodialism' being replaced by more wide ranging scales, that have had as their primary focus different attitudes towards the aetiology and treatment of mental illness. The most detailed study of the personalities of psychiatrists being that by Holt and Luborsky (1958) in the U.S. and by Kreitman (1959, 1962) in the U.K. (2). Although only stating their intention to consider its relationship with personality, Sharaf and Levinson (1957) have also developed a further ideology scale

(1) As they put it, "a punative orientation towards patients ... seems to stem from a displacement of aggressive impulses that cannot be expressed against their original object" (p.217).

(2) There have also been a series of studies by Walton et al (1963, 1964, 1969) on medical students, intending to specialise in psychiatry. They claim to have demonstrated that such students are different from others, showing greater reflexiveness, tolerance of ambiguity and favourable attitudes towards patients. Although Kreitman (1959) claims to have shown a relationship between 'introversion' and an 'analytic' orientation, he suggests that length of time in general medicine was the most important determinant of having an 'organic' orientation. Freeman (1968) has also carried out studies on the personalities of psychiatrists.

that they claim distinguishes between a Psychotherapeutic Orientation and a Sociotherapeutic. In the attitude scale that they developed (the PSI scale), which they claim distinguishes between these orientations, the majority of the questions relate to attitudes towards mental illness, and the management of patients. In the report of their study though, they give quotations from psychiatrists which suggest these attitudes cannot be segregated from the wider beliefs, that such staff hold towards their role in the hospital. However, such considerations are relagated to the background of the study, while the primary focus is on attitudes towards the treatment of mental illness. A surprising feature of Sharaf and Levinson's scale is the way an organic, or somatic view of mental illness is subsumed under the sociotherapeutic orientation, without any explanation being given for this decision. Also as surprising is the suggestion that the psychotherapeutic and sociotherapeutic orientations are diametrically opposed. Both Strauss et al (1964) and Ehrlich and Sabshin (1964) have suggested that these ideologies have much in common. An explanation for these features of Sharaf and Levinson's study can perhaps be found by considering the hospital in which they did their research. As it was small and 'engaged in a program of intensive treatment, teaching and research' (p.263) it might be fair to suggest that it was an 'elite' establishment, in which the main divisions were between a 'pure' form of psychotherapy, as opposed to a less exclusive 'milieu' approach. It is likely that even this milieu approach was quite different to that being carried out in the large state hospitals.

Sharaf and Levinson's failure to consider the 'organic' approach has been covered by the studies of Hollingshead and Redlich (1958) and MacIver and Redlich (1959) in which attention has been drawn to the existence of a 'directive - organic' as opposed to a 'psychotherapeutic -

analytic' orientation. They suggest that these two orientations were the main dimensions around which the two ideological groups in American psychiatry, cluster. Although they take a rather narrow view of psychiatric ideology, they do suggest that these ideologies can be related to a wide range of social and political attitudes, and have been determined by a wide range of experiences, both inside and outside their work situations (1). More recently, in what has become the best known study on psychiatric ideology, Strauss et al (1964) note that "we shall use the term ideology freely whenever we wish to refer to the 'psychiatrists' (and 'parapsychiatrists') ideas about the etiology and treatment of mental illness" (p.8). They then point out that they had started their study by assuming that there were three ideological poles around which psychiatrists and related specialists cluster. These they term the somatic, the psychotherapeutic and the milieu therapy or sociotherapeutic. And despite their warning, quoted at the start of this chapter, they use a lengthy and complicated attitude scale, which they claim revealed the existence of the ideologies that they had presumed to exist. The methodological problems of such questionnaires will be considered shortly, but before that it is necessary to mention several other studies in this area.

Apart from the many studies that have been conducted into the differences between staff towards specific treatments (2), the study that

(1) Rogow (1970) has also collected extensive material on the differing political, religious and social attitudes of different sections of American psychiatry. This issue will be considered again in Chapter 5.

(2) Studies by Klerman (1959, 1960) and Mason (1958) have dealt with attitudes towards drug use, while Sundland and Barker (1962), Kissinger and Tolor (1965) and Mowbray and Timbury (1966), Harper (1959) and Kubie (1963) have looked at beliefs about psychotherapy. There are also other studies such as those by Giedt (1959) and Ellesworth (1965) that deal with certain attitudes towards mental illness.

has the most relevance for the issues being considered here is that by Armor and Klerman (1968). In this study they seek to establish the empirical basis of the three ideologies that have been identified by Strauss et al. They claim that these ideologies should only be considered as existing if they can be shown to have a "coherent system of both existential and evaluative ideas" (p.245), and further that at least a sub-section of the profession 'identify' with it. Through the use of an ideology scale that they claim discriminates between the above ideologies, they suggest that whereas the somatic and psychotherapeutic orientations 'qualify' to be considered as ideologies, the socio-therapeutic orientation did not apply on the grounds of lacking "both etiological content and a strong comparative preference when compared with the other forms of treatment" (p.250) (1).

This view that sociotherapy should not be regarded as being an ideology, would appear to conflict with the earlier studies, especially that of Ehrlich and Sabshin (1963, 1964). They claim that this ideology "comprises a relatively independent and coherent set of beliefs and opinions that can be assessed with satisfactory reliability and validity by our instruments" (1964, p.479). However, there does seem to be some agreement that not many psychiatrists, or other staff, identify themselves with this ideology. For Ehrlich and Sabshin this is because the position is not 'prestigeful enough'. The findings of Strauss's study would appear to bear them out on this point. In that study, 70%

(1) This contention they claim was further borne out by the findings on self ascribed identity. 79% chose psychotherapy as their orientation, 11% chose somatotherapy and 10% chose sociotherapy. However, whereas the self identified somatotherapists scored highly on the somatic scale, 49% of the socio's, identified as being in the top 40% of the scorers on the sociotherapeutic scale, were also strongly identified with psychotherapy.

of the doctors identified with the psychotherapeutic position, 23% with the somatic, and only 7% with the socio. Among the psychologists, this last position was even less popular, as only 4% identified with it, the majority (96%) identifying with the psychotherapeutic position. The social workers were the most pro the socio position, with 21% identifying with it, while the remaining 79% identified with the psychotherapeutic (1).

Certain problems arising in the study of psychiatric ideologies

Bearing in mind the view of ideology that was presented earlier on in this chapter, it will be readily apparent why the previous approaches to the study of this problem are considered to be inadequate in various ways. The most serious criticism of these studies, that have nearly all relied heavily on the use of attitude scaling questionnaires, must be a methodological one. For it is believed that most of these studies have merely revealed what they set out to find, as a consequence of holding a narrowly defined conception of the sort of ideologies they expected to find. Studies that approach their material through the use of such 'objective measures' as attitude scales, have been increasingly criticised in recent years, for the way they violate the data they are studying, as an inevitable consequence of having to fit it into pre-determined categories (2). The importance attached to the 'measured' ideological differences has varied between these studies, but overall they have all assumed that ideologies constructed around attitudes towards mental

(1) This question of 'self identity' will be considered again in Chapter 6.

(2) This question was considered in Chapter 1 and will be discussed again in Appendix 1.

illness are the relevant ones to study in this area (1).

While it would appear that there are certain cleavages of opinion over the aetiology and treatment of mental illness, and that these differences have been expressed quite clearly in the United States, as in this country, it can also be argued that quite different 'ideologies' might have been revealed through a more inductive methodology. As it is, these earlier studies have failed to offer any account of how the identified ideologies are related to the social structure from which they spring. Instead certain ideas about mental illness and its treatment are reified into allegedly objective measures, in such a way that the social context in which these ideas are generated, and the consequences that these ideas have upon the social structure, are lost from sight. An alternative approach to the study of ideology, that begins by examining the way staff hold various beliefs, assumptions and ideas about the appropriate order of staff relationships, and each other's role towards the patients and one another, might reveal quite different ideological formations. Further, while not wishing to claim that the term 'ideology' has only one meaning, it is being suggested that if it is to be used at all, then it should not be shorne of any suggestion that the beliefs that make it up, reflect different interests. Instead primary consideration should be given to this aspect (2).

Apart from the above criticisms, that essentially call for an alternative methodological approach to the study of psychiatric ideology, a few lesser points can be made about the existing literature. To begin

(1) Significantly, Strauss et al appear to relegate the role of the questionnaire study to the back of the report on their work.

(2) The case for doing so having been argued in Chapter 2.

with, much of it can be criticised for seeking to reduce social phenomena to personality and other psychological factors. This approach, while being a legitimate one for a psychologist to follow, has also been allied with what can best be termed a 'management' frame of reference. That is the problem has been identified as being one of developing 'objective instruments', with which to identify staff who have the appropriate personality characteristics (1). A further point refers to the omissions in this literature. While there have been many studies of nurses, psychiatrists and aides, there have been very few that have also included psychologists and social workers. In several of the studies that have been referred to, the staff who have been the subjects of these studies would appear to have a fairly clear idea of their own ideological self identity. This finding would support the recommendation of Marx (1969) that researchers specify the theoretical referrents of the ideologies they are to study, before they develop their attitude scales. However, such a recommendation only has any value if identifiable theoretical positions have any meaning to the subjects of the study (2). In the study by Armor and Klerman, for example, they suggest that the majority of psychiatrists may not belong to any of the ideological positions that they identify, but instead may be 'eclectics'. This point relates back to the earlier one about the methodological and theoretical inadequacies of the approach, that has previously been taken to studying psychiatric ideologies, but it also raises the general problem of the

(1) See, for example, Cain and Small (1966).

(2) In fact in many of the studies the subjects had no choice, in that they had fixed choice questions to answer - for example the Strauss et al study specified the three ideological positions and asked the respondents to choose between them.

relevance of the American studies to the British situation (1).

The problem of the American studies on the psychiatric professions

Although this chapter is primarily concerned with the nature of psychiatric ideologies, it is appropriate to consider within it the general problems that arise from having to rely on a largely American literature, not only on psychiatric ideology, but also on the psychiatric professions in general. In Chapter 2, reference was made to this problem, because of the evidently greater conflict in the United States over the carrying out of psychotherapy. It was suggested then that the practice of psychotherapy has been much more extensive in the United States than in this country. The evidence of the ideological self-identities, referred to earlier on in this chapter would support this suggestion. Further, it was pointed out that psychotherapy has been largely practiced on a private basis, and thus there is also likely to be an economic conflict underlying the relationships between psychotherapists. Bearing in mind the highly developed structure of training institutes, associations and rival factions that exist within the world of psychoanalysis and its derivative forms, it is hardly surprising that mental health professionals in the United States are likely to be at least aware of the different 'ideological' formations, even if they do not identify with any of them. Further, if the fact that over 75% of such staff, surveyed in a recent study, reported that they were undergoing some form of psychotherapy,

(1) Marx (1969), for example, takes a political science view of ideologies, that is similar to that of Geertz (1964). Accordingly he suggests that ideologies are 'consensually validated and coherent belief systems'. He suggests that such ideologies arise because of the uncertainty surrounding treatment, but such uncertainty is as likely to engender belief 'systems' that are neither consensually validated nor coherent.

is considered (1), then it is hardly surprising that many psychiatric professionals in the United States are 'committed' to not only this approach to therapy, but also to particular factions within the field of psychotherapy (2).

There are also other general features of the structure of the American health services that might have a bearing on the apparent conflict between the different psychiatric professions. Both Smith (1955) and Glaser (1963) have drawn attention to the way American hospitals have much more complex and functionally separate business and organisational structures, than is usually found in European hospitals. This means that in European hospitals much greater power and authority is combined in the hands of the senior doctor or doctors. According to Glaser, the fact that over three quarters of the income of doctors in the United States comes from private practice, structures their relationship not only with one another, but also with the other staff (3). He alleges that considerable resentment is expressed by the non medical staff over the 'neglect' shown by doctors towards not only the patients in hospital, but also towards their own opinions, hopes and ambitions. Further, when the requirement on junior doctors to be mobile between hospitals is considered, there would appear to be little opportunity for any stable relationships to develop between the medical and non medical staff. In contrast, Glaser suggests that in Europe, the doctors stay for longer periods in one hospital, often working their way gradually up the hierarchy. Greater deference is shown

(1) This question is considered again in Chapter 9.

(2) See Sundland and Baker (1958), Harper (1959).

(3) In this context the classic study by Hall (1948) provides relevant material in the career structures of American medicine.

to senior doctors by the junior doctors, and to the junior doctors by the other staff. This deference being legitimised, not only by the cultural traditions surrounding positions of authority, but also by the lower levels of training and expectations to be found among nursing and other staff. Altogether, Graser suggests the cultural expectations that relationships be egalitarian, and the greater willingness to express grievances and criticisms by staff who are more questioning of the doctors authority, has led to higher levels of expressed dissatisfaction, in American hospitals than those found in Europe (1).

Evidence for this contention that non medical staff in hospitals in the United States are very conscious of, and critical towards, differences of status and prestige, can be found in a series of studies of mental health staff (2). While they differ in some respects, all these studies show that the clinical psychologists and especially the psychiatric social workers were resentful of the way they felt they were excluded from certain decision making processes, and further felt considerable disparity between what they thought their status ought to be, compared with what it was recognised to be. As Dinitz et al (1959) observed

> "Social workers aspire to and believe they have a high status but in actuality have a low status in the eye of the general public as well as in the opinion of other professional persons. One might say in summary that the social workers have a strong status orientation; their status is of crucial significance to them" (p.58).

(1) This egalitarianism can be seen to have other social consequences, such as those observed by Merton (1957).

(2) Lefton et al (1959), Dinitz et al (1959), Jacobsen et al (1959), Rettig et al (1960).

This suggestion has also been backed up by Rushings (1964) who found that the social workers in the hospital he studied, were very concerned about their lack of status in the eyes of nursing as well as the medical staff (1). A further point to emerge, especially in the study by Lefton (1959) is the way that 'team work' can exacerbate the felt differences. Also in this study, and that by Dinitz et al (1959), it was found that the staff working on the more organically orientated units were less dissatisfied than those on the more psychotherapeutic and therapeutic community units.

This digression may not appear to be directly relevant to the issue of psychiatric ideology. However, it is believed that the structure of American psychiatric practice and health services as well as certain cultural features (2), have led American mental health staff to articulate more clearly, the differences between themselves, than is the case in Britain (3). It has also been suggested as long ago as 1935, that

> "there is a general lack of definite systematic adherence among British psychiatrists, apart the extreme psychoanalysts, but these latter do not constitute a truly significant group in relation to British psychiatry as a whole" (Line, 1935, p.1064).

Further, he goes on to suggest that

(1) In a study by Jacobsen (1959) the same was found for the clinical psychologists but in a follow up study by Moss (1961) it was claimed that there was little dissatisfaction over status differences as such. In Rushings (1964) it is noted how the psychologists had 'faculty status' while their teaching and research work gave them a higher status, even they were still resentful over their subordinate role in some areas.

(2) Berger (1965) has drawn attention to the way psychoanalysis provided a solution to the crisis in American culture that as its central feature a search for identity.

(3) In Chapter 10 there will be a further consideration of this issue.

> "Throughout we have noted the eclectic nature of the thought of some representative psychiatric leaders, and the tendency for different points of view to be manifest among the staff of any one institution" (1065).

Line concludes his article by suggesting that 'these trends are directly opposed to analogous tendencies in American thought'. A point that has been verified by Strauss (1964) who has drawn attention to the way psychiatric institutions in the United States can be characterised as representing particular ideologies.

There is clearly a danger of attempting to categorise particular countries in such general terms, without giving due reference to the differences and contrasting shades of opinion and practice within them. At the same time, certain countries can be shown to have produced, and to have been influenced by different philosophical traditions of thought. Thus it might be supposed that the empiricist tradition of British thought would engender a distrust of theoretical ideas and abstract systems in general (1). The consequences of this distrust being found in such areas as the treatment of mental illness. However, while 'eclectic' thinkers often claim to be 'non-ideological', it can be suggested that this view of social reality should itself be seen to be part of an ideology, especially when identifiable interests are being defended through it.

Conclusions

To summarise the main points from the studies that have been referred to above, it would appear that firstly psychiatric ideologies arise

(1) The particular influence of empiricism on the development of clinical psychology as an occupation will be referred to in Chapter 4.

primarily over differences of opinion over the treatment of mental illness. Secondly adherence to particular ideological positions would appear to be related to membership of certain occupations. Thirdly both the clinical psychologists and psychiatric social workers would appear to be very dissatisfied with their current status and role within mental hospitals. These studies have nearly all been carried out in the United States and thus may have little bearing on the situation in Britain. However, they have been examined as providing indications of possible lines of enquiry and a starting point for a study that also raises some of the same issues as these other studies.

This literature influenced the early course of this study in various ways and provided several initial assumptions that guided the early field work, and therefore it is relevant to draw attention to it. In particular, it was thought that the clinical psychologists and social workers to be interviewed would have a clearly formed and readily articulated sense of their own professional identity, as well as giving expression to competitive attitudes towards the other staff. Fortunately because of the decision to approach this study as an exploratory one, the earlier literature was only taken as a guide to possible avenues to explore, rather than as a blue print to be tested. Besides for the reasons that have already been noted, there are certain fundamental weaknesses in the earlier literature on psychiatric ideology. Its narrow focus and methodological rigidity has meant that the 'ideologies' that have been identified have only a tangential relationship to the questions of authority and control. It might be argued that it was never the intention of the authors of these studies to consider such questions, but this omission has meant that their studies only provide information on certain attitudes, without saying anything about the bearing that the

holding of certain attitudes has on the social structure of the treatment settings.

It was argued in Chapter 2 that one way of approaching the study of professionalisation was through the ideas that were expressed about this process by the participants themselves. Where such ideas appear to reflect a view of the world that serves to justify that person's position in the world, then it might be termed an ideology. For this reason a much more broadly based view of ideology should be taken than that embodied in the previous conception of 'psychiatric ideology'. In Chapter 6 there is a description of the ideological formations that emerged during the analysis of the interviews. It is believed that these ideological typologies have a bearing on the problem of professionalisation as posed in the previous chapter. In particular they demonstrate how the desire to become 'professional' and the meaning given to having control over one's work, are as important components of an ideology as are beliefs about the treatment of mental illness.

CHAPTER 4

THE THREE MENTAL HEALTH OCCUPATIONS: THEIR PAST DEVELOPMENT AND PRESENT POSITION

Summary: This chapter contains three separate accounts of the past development and present position of the occupations being studied. The common theme within these accounts is the 'professionalisation' of these occupations, and thus attention is drawn to the problems that these occupations face in developing, among other things, distinctive bodies of knowledge. These accounts also provide an opportunity to bring together information from past studies, that has a bearing on issues that are subsequently explored in the analysis of the field work.

> "The development of many professions auxilliary to medicine in Britain is the history of how physicians have been able to define the scope of new specialised medical roles, and cannot be regarded as a hierarchy of semi professions based upon the inherent potentialities for the professionalisation of each group, or even as the product of the most rational utilisation of human resources" (Johnson, 1972, p.36).

More than any other area of medical activity, the treatment of 'mental illness' provokes public controversy and the intervention of lay therapists. The very nature of madness, its incomprehensibility and the threat it poses to the social order, has meant that the 'treatment' of it has always raised ethical and ultimately political questions about the nature of man and society. Studies such as that by Foucault (1965) have demonstrated how the position of the madman, the regard in which he was held, the theories that were advanced to explain his condition and the way he was treated, have changed over the centuries. Conventional medical and social histories regard such changes as signs

of the progress of reason and science over ignorance and brutality. The way in which madness became mental illness is frequently cited as an example of progress and increasing civilisation of western societies. Similarly, the growth, elaboration and increasing sophistication of the health and social services have been regarded as signs of a more humanitarian society (1). An important element in this 'progress' being the increasing size and diversification of the professions that service the mentally ill and their dependents.

While there would appear to be acceptance in some quarters that madness should be regarded as an illness, in recent years an increasingly influential critique has been presented of the methods, models and activities of medical psychiatry (2). Whether rightly or wrongly, this critique has brought psychiatry and the treatment of mental illness much more into the public eye than at any time since the scandals of the nineteenth century. At the same time there are certain organisational changes taking place; instead of being contained and isolated in large asylums, the mad, or as the medical profession would have it, the mentally ill, are now to be treated in the community in a variety of medical and non-medical settings. These changes have again been heralded as signs of medical progress in the same way as the construction of the asylums was justified in terms of the provision of medical care and cure (3). The construction of psychiatric units attached to District General Hospitals has recently been described in

(1) One recent exponent of this view has been Halmos (1970).

(2) Reference was made to this critique in Chapter 2, pp. 26-28, and further on in this chapter it will be noted once again.

(3) Rothman (1971) has provided a detailed account of this in the American context.

the following terms,

> The treatment of psychosis, neurosis and schizophrenia has been entirely changed by the drugs revolution. People go into mental hospitals and they are cured, and that is why we want to bring this branch of medicine into the scope of the 230 District General Hospitals that are planned for England and Wales ... Now psychiatry is going to join the rest of medicine - but it will take time" (Sir Keith Joseph, 1971).

But as Rothman has pointed out such changes are always social changes, they do not simply arise because of a change in technology, or even because of a change in ideas as Foucault suggests, unless these changes are also consonant with underlying social, cultural and economic conditions. A history of the rise of the medical specialty of psychiatry would require a detailed analysis of the role of the medical profession at a time when the contradictions within an emerging capitalist mode of production were at their acutest. The growth of the asylums as a social invention that was legitimised by the medical profession, arose at a time when there was an increasing need to segregate those who were unwilling or unfit to sell their labour from those who were. Asylums became the main institutional form of control created by the middle classes when faced with apparently an increasing number of mad and mendiant misfits. The eugenics scares towards the end of the century being both a cause and consequence of this increase. Along with other medical specialties, psychiatry developed through its classifications of symptoms, syndromes and conditions that appeared to be the first stage to developing the 'scientific' study of madness. Psychiatrists were soon joined in this activity by psychologists, who made their first notable contribution in the field of mental deficiency (1). The

(1) Ryan (1974) has provided a useful account of the way the medical profession took control of mental deficiency asylums in the early part of the nineteenth century. She further notes how the early psychologists, such as Binet adopted a medical frame of reference to their work and thus supplemented rather than supplanted the psychiatrists.

task of identifying people in need of asylum care fell upon the Poor Law Medical Officers from the 1830's onwards. Other occupations have continued to play some part in this process, but the medical profession has generally managed to define them as subordinate to themselves.

The rise of psychiatry as an occupation, and to a lesser extent clinical psychology has been intimately connected with the rise of asylums in the last century. In contrast the increasing involvement of social workers with mental patients, can be associated with the demise of these asylums (1). 'Psychiatric' social work developed more strongly in child guidance clinics and local authorities than in mental hospitals, but its development has also been shaped by the already dominant position of the medical profession in the main centres of care for mental patients. Social workers have increasingly gained control over their own affairs and over work that does not involve other occupations, but the treatment and care of officially recognised 'mental patients' whether inside or outside of mental hospitals, generally involves contact with the medical profession.

Three separate accounts of the past development and present position of these occupations are given in this chapter. The histories of these occupations inevitably become entwined, but it was decided to treat them individually so as to give due attention to the distinctive features in their development. Throughout these accounts attention is directed to the 'professionalisation' of these occupations: but the intention is not to provide three parallel descriptions. Instead, the

(1) Cohen (1974) has drawn attention to the way various forms of 'community care' are replacing the largely discredited asylums, as the new means for controlling deviants. Social workers are playing an increasingly important role in the administration of these 'institutions'.

focus will vary according to the problems that each occupation has appeared to have faced. The focus has also varied according to the available literature on these occupations, social workers having received much more attention from sociologists than either psychiatrists or psychologists (1). The lack of sociological studies on these occupations being one justification for undertaking this study.

The Psychiatrists

In 1788 Dr. Francis Willis was appointed to treat George III. This event has been regarded as of

> "considerable importance in the history of madhouse proprietors and 'mad doctors' in general. It brought some professional respectability to the 'trade in lunacy' and demonstrated that the treatment of insanity required special skills and experience not necessarily presented by the most eminent physician of the day" (Parry Jones, 1972, p.75) (2)

Jones also noted how in the late eighteenth century, there had been the emergence of specialisms and the increasing professionalisation of medicine with the establishment of voluntary hospitals in London and the provinces. In particular he suggests that

> "the methods adopted at a small number of new lunatic hospitals, such as St. Lukes Hospital in London, and the Manchester

(1) There are many 'psychiatric historians' who have provided detailed accounts of either the life and activities of individual psychiatrists, such as Walk (1959, 1961), Stern (1961), Leigh (1961), Lewis (1961, 1963) but there are few histories of psychiatry as an occupation. There are several histories of social work but only Timms (1964a) has provided a detailed account of the rise of psychiatric social work. The account given in this chapter relies heavily on this work, but the recent reorganisation of social work has raised certain problems about such histories of the now defunct specialties. Hearnshaw (1964, 1969) would appear to be current leading historian of clinical psychology, but once again there is no single available source on the rise of this occupation.

(2) Macalpine and Hunter (1969) also draw attention to the significance of this appointment (p.269).

> Lunatic Hospital, played an important part in raising standards in the treatment of insanity. The assumption of medical responsibility for the insane, however, was a slow process, particularly in private mad houses, and the 'mad doctor' had little social or professional status" (p.74) (1)

Psychiatrists commenting on their history make due reference to the 'slow process', such reference serving to emphasise the significance they attach to the recent adoption of full medical responsibility, since the 1959 Mental Health Act (2). Further, the current government policy to establish psychiatric units in District General Hospitals has been heralded as meaning "... the reintegration of psychiatry in medicine - a process which many have worked for but which has not been possible for several centuries" (Hill, 1969, p.17). The task of this section on the past development and current position of the medical specialty of psychiatry, is to consider some features of this process, and to question how far it can be considered to be complete.

One way of approaching the history of the rise of psychiatry as a medical specialty is to examine the various legislative changes over the last two hundred years, that have increasingly defined the care of lunatics/the mentally deficient/the mentally ill as being the concern of the medical profession. Kathleen Jones (1955, 1960) and in her revised edition (1972) has provided the most detailed record of such changes and this brief account relies heavily on her work. However,

(1) Kathleen Jones (1972) also considers the establishing of St Lukes in 1751, and the Manchester Lunatic Hospital in 1763 to demonstrate increasing interest by the medical profession in mental illness "For the first time, the treatment was recognised as being allied to the treatment of bodily illness and to be sought without shame or secrecy" (p.45). Brockbank (1934) has documented the way the same procedures were applied to the lunatics as to the ordinary patients, and the way only the physicians could admit patients.

(2) See, for instance, Stafford Clark (1963), Lewis (1961), Walk (1959), Hays (1964).

her interests are much broader, than simply the particular question of the adoption of medical responsibility, which she treats as an incidental development. For Kathleen Jones, the 1774 Act for Regulating Private Madhouses (14 GEO III C9) was significant in this context, because among other things, it established the supervision of the medical profession over the issuing of licences to mad house proprietors. This supervision was hardly adequate to the task, and as she points out, the question of false detention, and the need to control the activities of the mad house proprietors were matters of continuing controversy throughout the following century (1).

The precise history of the increasing institutional involvement of the medical profession in the care of the mentally ill is difficult to disentangle. Kathleen Jones has noted how an amendment in 1815 to the 1805 Wynn's Act that had established the County Asylums, required the overseers of the poor in each parish to provide medical certificates for each of their lunatics and idiots. Some years later the Lunacy Regulating Act of 1853 required the specification of the medical practitioner's qualifications on such, and other certificates. Though it was not until the 1858 Medical Registration Act that control was achieved over who was a 'qualified medical practitioner' (2). By the

(1) In contrast to Kathleen Jones who is very critical of the role of the private mad houses, Parry Jones has suggested that they have been much abused, and their valuable contribution has been neglected.

(2) According to Parry Jones, there was not only conflict between the medical and lay elements over the care of the insane, but also within the ranks of the emerging medical profession. The physicians who were predominantly in London, tending to view with some distain the provincial alienists who were often surgeons or apothecaries. the latter group though were the first to regularise their position by the Apothecaries Act of 1815 (p.90).

late eighteenth century there had been a considerable growth in the numbers and size of County Asylums. In the earlier part of the century, lay superintendants had sometimes been appointed, though as Kathleen Jones points out, the Commissioners in Lunacy advocated a policy of medical control. While this was established in the County Asylums by the middle of the Nineteenth Century Parry Jones has recorded how as late as 1870 only 38 of the 64 provincial (private) licenced houses were licenced to medical practitioners (p.89). Quite apart from the Commissioners in Lunacy's recommendations, the Association of the Medical Officers of Lunatic Asylums, formed in 1841, was also active in promoting the cause of the medical element in the care of the insane. As an editorial in the second issue of the Asylum Journal of Mental Science, founded in 1854, stated

> "Insanity is purely a disease of the brain ... the physician is now the responsible guardian of the lunatic and must ever remain so". (Quoted by Kathleen Jones, pp.155) (1)

While many claims were being made for the ability of the medical profession to cure lunacy (2), the reasons behind the appointment of medical men to the position of Superintendant appeared to be firstly to ensure some level of physical care in institutions in which there were increasingly

(1) Bucknill, a leading alienist of the day, and a mad house proprietor who was particularly opposed to lay involvement in the care of lunatics, writing in the Asylum Journal of Mental Science in 1857, Vol. 3, pp.19-20 argued that "If insanity is a disease requiring medical treatment, ladies cannot properly or legally undertake the treatment ... with laymen and ladies the medical treatment of insanity is out of the question, and a licence granted to them becomes merely a permission to speculate upon their maintenance". Walk (1961) has questioned Jones' interpretation, and claims Bucknill was not totally opposed to lay involvement.

(2) Parry Jones (1972) has provided a graphic account of the various claims and the competition between the mad house proprietors over who had the highest rates of cure.

large concentrations of people, and secondly that members of the medical profession, especially after the 1858 Medical Registration Act, were to be at least accountable and 'responsible' members of society (1).

The 1890 Act, which followed the various scandals of the 1870's and 1880's over the detention, and certification of patients against their will, has been regarded as a 'triumph' of legalism' by Kathleen Jones. As a result of this Act, the legal authority of a magistrate became necessary for the detention of a person as a lunatic. This in itself did not prevent subsequent scandals over false detention, and the Royal Commission on Lunacy and Mental Disorders of 1924-26 was set up to investigate the legal safeguards for patients. The Commission took a very broad view of its tasks, and its report went some way to affirming how 'mental illness' as it was now termed, should be treated in 'hospitals' (instead of asylums), like any other physical illness. In order to facilitate early treatment, the Commission recommended the extension of voluntary treatment and the setting up of out-patient departments, and observation wards in general hospitals. While the subsequent Act went some way to confirming the medical viewpoint over the treatment of mental illness, it was not until the 1959 Mental Health Act, that the medical

(1)As late as 1908, the Commissioners in Lunacy considered that the primary task of an asylum was to "separate from their fellows those unfortunate persons whose mental infirmity illfits them for ordinary life or renders them unsafe to be at large, or requires them to be carefully protected from their insane impulses. In a word they need to be taken care of. They also require to be treated for their disorder - the treatment depending to a large extent upon judicious moral management, a bright and cheerful environment and the encouragement of measures towards the strengthening of weakened will (62nd Report, 1908, p.17). A study of the Annual Reports reveals the primary concern was with the physical well being of the patients and any untoward deaths, etc.

profession was given almost complete legal jurisdiction over the admission, detention and discharge of patients. Finally the policy that was set out in 1962 of closing down the mental hospitals, while replacing them with psychiatric units attached to general hospitals, has been hailed by many psychiatrists as setting the communities' seal of approval on their claim that the treatment of mental illness should be primarily a medical problem (1).

A necessarily foreshortened view of the developments that have led up to the medical profession's dominance over the treatment of mental illness has been given. Such developments are generally interpreted by psychiatrists as signs of the progress of both their own profession and the wider society. Hill (1969), among other psychiatrists, believes that the current policy of closing down mental hospitals will bring psychiatry back into medicine, and thereby enhance its status as a medical activity. However, psychiatry, for some time to come, will continue to be carried out in mental hospitals, and it is therefore worthwhile noting some of the consequences that appear to have stemmed from 'isolation' from the rest of medicine.

Quite apart from the generally low status that was attached to 'asylum work', the segregation of psychiatry in the mental hospitals, allegedly led to its almost total neglect in the training of medical students (2).

(1) Hospital Plan for England and Wales, HMSO Cmnd 1604 (1962). K. Jones has provided a useful summary of the events leading up to this policy statement.

(2) There are certain graphic accounts of life in the asylums both from the point of view of the patients and the staff, that demonstrate the low regard that asylum work was held in. For example, Zale (no date, but around the turn of the century) novel, 'In a County Asylum' describes the life of an assistant medical officer in an asylum. His main duty being to keep the maintenance costs down and ensure there was 'no trouble' through the use of massive dosages of Sulphonal. More recently Sargant (1967) has described his experiences as a junior doctor at Hanwell in the 1920's, while Delaney (1971) has described hers in a hospital in Wales in the late 1940's. In both these accounts there are references to the way many of the other doctors had chosen their present posts for a quiet life, while Delaney suggests several were alcoholic or drug addicts, or generally seeking refuge from the outside world.

A report of the Medico-Psychological Association in 1914, on the Status of British Psychiatry and Medical Officers, drew attention to many of the undesirable features of the life of the assistant medical officers, and noted the general lack of training facilities and the lack of incentives to pursue higher qualifications. Some years before this in 1893, the G.M.C. had sent around a circular proclaiming that mental disorders should be part of every medical students training. It is doubtful whether many medical students received any instruction, partly because of the problem of getting access to patients, but also because of the low regard in which psychiatry was held by the rest of medicine. As well as the lack of training in psychiatry for medical students, a more serious matter was the apparent lack of any specialist training for intending psychiatrists. There are records of occasional lectures and courses for doctors that go back to the founding of St Lukes and beyond. However, it was not until 1886 that any qualification as such was established, this being the Certificate in Psychological Medicine. By itself this was of limited value as it was awarded after only three months clinical experience in mental disorders, and attendance at a course of lectures. This soon lapsed and it was not until 1910 that the Royal College of Physicians established a Diploma in Psychological Medicine (1). While this diploma has become regarded as the main post-graduate qualification for psychiatrists, it has been the subject of much criticism in recent years, as have the lack of facilities for study in most mental hospitals.

(1) Lewis (1961, 1963) has provided detailed accounts of the development of psychiatric education.

Another related consequence of the segregation of psychiatry, and also of the legal requirements surrounding certification in the early part of this century was the almost separate development of psychoanalysis in this country. Hill (1969) suggests the early interest in psychoanalysis came largely from neurologists working in the teaching hospitals, and that until the First World War there was no appreciation of the need to include the study and treatment of the neurosis in the training of psychiatrists (1). Even after the war, when increasing interest was being shown in the 'war neuroses' he considers that the split between the psychiatry taught in medical schools (psychological medicine) and that practiced in the large hospitals continued. The significance of this split will be noted in the other sections of the development of clinical psychology and psychiatric social work, for both developed an early interest in the neuroses and other milder behaviour disorders, that were allegedly being neglected by the psychiatrists.

Returning to the particular question of the education and training of psychiatrists, a few general points can be made about the current position. In recent years there have been several reports that have drawn attention to various inadequacies in the training of psychiatrists (2). The very rapid rise in the number of consultant posts for psychiatrists in the 1950's and 60's, allegedly led to promotion of many 'poorly'

(1) Kathleen Jones makes a somewhat similar point, by suggesting that the 1890 Act meant that the mental hospital psychiatrists only had experience of the 'worst' and grossest forms of disturbance. This led to a general pessimism about the possibility of recoveries, with a consequent neglect and decline in standards even of physical care in these hospitals.

(2) Davies and Shepherd (1963), Hill et al (1963), Carstairs et al (1968), Russell and Walton (1970) and Brooks (1973) and many other articles expressing different opinions about the problem.

qualified doctors to these positions (1). The conflicts that have arisen over the creation of the Royal College of Psychiatry appeared to have stemmed partly from the question of who to include or exclude as founder members, in view of the lack of post-graduate qualifications among some consultant psychiatrists. The creation of the Royal College has enabled psychiatrists to gain greater control over the training and qualification of psychiatrists. However, it is only recently that psychiatrists have been given this recognition. In 1944 the Goodenough Committee enquiring into medical education did not call for evidence from the RMPA as it then was. The standing of psychiatry in medical schools has also been strengthened by the creation of more professional chairs, but as recently as 1968, it was reported that the average medical student only spent 185 hours on psychiatry throughout the whole of his education (2). It also appears that interest in psychiatry as a career choice declines with each successive year as a medical student (Last et al, 1969). Further, it would appear that those students who decide on a career in psychiatry, are not the most academically successful students (Last and Stanley, 1967), even though intending psychiatrists may have more academic and cultural interests than other students (3). But once they are working as psychiatrists, they appear to carry out very little research themselves (4). This suggests that psychiatry as a

(1) Between 1947 and 1959 the number of consultant posts in psychiatry increased by 52% whereas the average for other specialties was 32% (Patterson, 1959). According to Russell and Walton (1970) in 1956 there were 566 consultant posts in psychiatry, by 1967 this had increased to 1,153. The rate of expansion has declined in recent years, but there are still vacancies in such areas as subnormality and child psychiatry.

(2) Carstairs et al (1968).

(3) Walton (1964, 1969).

(4) Russell and Walton (1970).

discipline must rely on other disciplines and other branches of medicine and the natural sciences for the development of its own knowledge and techniques.

Throughout the debates on the reorganisation of medical education in general, and psychiatric education in particular, there has been a continuing controversy over the relationship of psychiatry to the medical and social sciences (1). Psychiatric educators are here faced with a dilemma, for the more they move away from medically respectable neurology or biochemistry, towards psychodynamic theories of personality development or sociology, then the more of an outsider psychiatry becomes in the medical schools. However, if these disciplines are ignored, then psychiatrists find themselves ill equipped to deal with the world of social relationships and personality dynamics. Further, as there are other non medical specialists concerned with the world, psychiatrists find themselves to be not only marginal men in relation to medicine, but also towards the many other staff who treat mental illness (2). The development of psychoanalysis and its derivative methods as a major form of therapy, especially in the United States, has posed particular problems for psychiatrists, as psychoanalytic thought and practices have developed largely outside the control of the medical schools and

(1) This controversy has found expression in the debate over the setting up of the Royal College. It has also been expressed in the writings of certain well known psychiatrists such as Sir Aubrey Lewis (1956, 1961), Sir Dennis Hill (1969), Shepherd (1973), Sargant (1966, 1967), Stafford Clarke (1963). It has also found expression at various conferences set up to discuss the training and future role of psychiatry (Russell and Walton, 1970 and Brook, 1973).

(2) Smith (1955, 1957) has provided a very illuminating analysis of this. While Zinburg (1963) has also drawn attention to the dilemmas that this creates.

colleges (1). This has meant that psychiatrists make no claim to have a monopoly of skill or knowledge over the practice of these forms of therapy, as they can over other areas of medical practice. Bearing in mind the assumptions that are built into medical training, that the medical practitioner will be responsible for his patients health and therefore can expect to be deferred to, and obeyed by the non medical, ancillary staff (2); the neophyte psychiatrist is likely to encounter many problems on entry to his first appointment in a mental hospital or psychiatric unit.

This aspect of medical education has been frequently referred to as creating problems for all medical specialists, not simply those taking up psychiatry. However, it has also been suggested that the problem is acutest among doctors entering psychiatry. The difficulties being even greater when the neophyte psychiatrist begins work in a therapeutic community setting (3). The approach that has been taken to analysing the dilemmas that face such psychiatrists has often stressed the psychological problems. Halleck and Woods (1962), for example, have examined the 'emotional problems of psychiatric residents' and have drawn attention to the period of residency as being a 'time of extraordinary

(1) See Smith (1955), and more recently Rogow (1970).

(2) Freidson (1970) has provided the most extensive and detailed analysis of this side of the medical profession. Work done on the socialisation and training of doctors has also drawn attention to this facet of medical education. See, for example, Becker et al (1961), Merton et al (1959), Levinson (1967), Bucher (1969).

(3) In the literature on therapeutic communities, there are frequent references to these problems, for example, Clark (1964), Jones (1956), Jones and Rapoport (1957), Cummings (1964), Rapoport and Rapoport (1960), Maine (1964).

stress in the life of the prospective psychiatrist, a stress which may have a profound effect on his personal well being, and his subsequent professional adequacy'. As well as drawing attention to the problems such residents faced with other staff, Halleck and Woods stress the way becoming 'psychologically minded' leads the resident to become 'more introspective and aware of his own problems ... at this stage in the training the patient's problems may become his own'. They note how the failure of patients to improve may foster his feelings of inadequacy at managing psychotherapy. Sharaf and Levinson (1957) have also drawn attention to these problems, which they summarise in the following way:

> They are **immediately** faced with anxiety rousing tasks which their medical training ill prepares them to meet. Despite their high formal status and prestigeful connotations of the medical man for the other personnel, for almost all residents the first weeks in the hospital produce a shattering impact, a sense of helplessness and ignorance. In no other residency is past training of so little relevance in coping with the required tasks, in no other residency does past training so little distinguish the physician from other personnel in terms of functional knowledge and skill in dealing with patients. (p.279).

They suggest that one way of coping with these strains is the development of an ideology that helps answer the question "what kind of social world am I in? and what am I doing here?" Another way is to become increasingly involved in practicing psychotherapy, as they put it

> "... competance in psychotherapy, permits him again to justify his high formal status as a physician with specialised techniques and achievements" (p.280).

In a further article Sharaf and Levinson (1964) have drawn attention to the [illegible] strains that are set up when a resident applies for admission to a psychoanalytic institute.

These strains are in part engendered by the peculiar relationship that residents have with their own supervisor, who is also likely to be the person who can recommend, or discourage the acceptance of the resident into a training programme. Several other writers have drawn

attention to the contradictions within the relationship between supervisor to 'student' or trainee, when the former has the dual task of acting as an assessor of the latter's abilities, whilst at the same time expecting him to reveal and discuss his problems, weaknesses and self doubts with him (1). Martin (1962) has also drawn attention to the contradictions in this relationship, as being one of the social structural sources of strain within a mental hospital. Following Merton (1957) analysis of role conflict, Martin has drawn attention to the way residents are faced with innumerable triadic relationships, such as that between himself, the social worker and the family, and that coalitions develop within these triads. Because of the asymetric nature of these relationships, the resident is first of all expected to resolve the conflicts, while secondly his attitudes and actions can have considerable effect on the ability of ancillary staff to carry out their work, whereas his own is relatively little affected by them. Because of his power to veto the actions of other staff, they often have to resort to informal and 'illegitimate' sanctions to bring him into line (2). His actions are almost constantly being observed by staff with a lower status but often more experience, who may in settings where there

(1) This problem of course applies mainly in settings where the student is intending to become a psychotherapist or to use his/her personality as an active part of the therapy. Szasz (1960) has written at length on the contradictions of this relationship. Heraud (1972) has also analysed social work students attitudes towards their supervisors, and revealed the dilemmas that such relationships engender. Olesen and Whitaker (1968) have noted similar problems for nursing students in a 'psychologically minded' school. Many psychotherapists have themselves analysed the problems from their own standpoint, as for example Blum and Rosenburg (1968), or Ford (1963) who analyses the problems in terms of the 'primitive identifications and objects from the preoedipal and oedipal years' having influenced the choice of psychiatry as a career.

(2) The study by Rushings (1964) also deals with the informal and underhand strategies that lay staff have to resort to to get their own way.

is an egalitarian ethos, freely criticise the resident. Such observations and comment, may restrict the freedom and autonomy of the doctor, but the conflicting expectations may enable him to gain some freedom by playing one member of staff off against another. The crux of the problem being the fact that as a physician, his authority can be seen to derive from his superior knowledge, but

> "when he begins psychiatric training this expertise is of little value ... unlike his conventional medical knowledge, which in part is being surrendered, the knowledge and expertise that he now aspires to gain are not exclusively his own, not only the new knowledge, but often also its application have already been shared by others - a source of some irritation" (p.351).

Like Martin and Sharaf and Levinson (1957) most of the commentators on the relationship of psychiatrists to other staff have noted the irrelevance of much of the psychiatrists previous medical knowledge. The studies that have been undertaken, have for the large part, concentrated on the various ways that individual members of staff, or groupings of staff have sought to resolve the conflicts that have arisen among themselves (1). The problem is seen to be one that can be 'negotiated' and bargained over, as if it can be resolved, if only temporarily, within the settings concerned (2).

Many psychiatrists openly admit their lack of distinct knowledge, but in recent years have made increasingly outspoken claims for the

(1) For example, the study by Strauss et al (1964) deals in some detail with the various tactics, strategies and methods by which working relationships were maintained. Schatzman and Bucher (1964) deal with this in more detail, while Rushings (1964) also approaches the question from this level. In the more policy orientated studies, the problem has often been seen to be one of 'role blurring' and 'role conflict' (Cummings, 1968). The 'therapeutic' community studies (referred to in footnote 3, p.68) also often see the problem in these terms and concentrate on improving 'communication' as the way to resolve it.

(2) Bucher and Stelling (1969) and (1970) have advanced a theory of 'professional organisation' that stresses these processes. See Chapter 10.

effectiveness of distinctly medical therapies. In an attempt to "re-establish the clinical unity of psychiatry with medicine," Sargant (1966) has listed all the advances made by physical medicine. The most notable being the discoveries of ECT, leucotomy and the phenothiazine drugs (1). In the frequent references that are made to the 'three revolutions' within psychiatry since the last war, some writers such as Hill (1969) claim two to have been medical and only one social, that is the legal revolution of the 1959 Act. Whereas others such as Kathleen Jones (1972) consider that the two most important were social. One of these being the creation of the 'community care' services. However, despite the 'successes' of psychiatry, such as the shorter length of stay in hospital, and the apparent relief from symptoms given by many drugs, psychiatrists have not yet managed to lift themselves above and beyond the repeated criticisms that are made of them from various quarters. More than any other branch of medicine, psychiatry becomes involved in public controversies in which the judgements, knowledge and even sanity of psychiatrists are called into question. In Chapter 3 attention was drawn to the way the 'social control' functions of psychiatry undermine the service basis of the relationship between psychiatrists and their patients. While psychiatrists may no longer be represented in the media as "brutal mad doctor using a whip upon an unfortunate patient" (2), they are still portrayed in a mainly negative

(1) He also includes insulin coma, sleep treatment, vitamin therapy, barbiturate and endocrine therapies, anti depressant drugs and several kinds of ECT and leucotomy. The address suggests the pertinance of Smith's (1957) comment that "(psychiatry, is and behaves like a minority group within medicine, revealing greater sensitivity to the tasks of 'selling' psychiatry to medicine, and hailing dramatic cures as if proof of its validity".(p.313).

(2) Tuke, quoted by Kathleen Jones (1972, p.156).

light (1). To a large extent psychiatrists are not taken seriously, and often bring ridicule on themselves when they make prognostications on all manner of social, cultural and human affairs (this tendency being much more marked in the United States). While some psychiatrists may wish to restrict their role to treating patients with identifiable organic conditions, there are others who have expanded their role to cover almost all known forms of human distress and social problems. The list of areas that psychiatrists have involved themselves in is a long one (2), and it has been this extension of their role under the guise of 'community mental health' programmes that has led to the repeated criticisms by Szasz (1960, 1963, 1965, 1970, 1973) from the 'right' and others on the 'left' such as the anti psychiatry group (3). This point was raised before in Chapter 2, and need not be laboured here. However, it should be noted that there are several fringe groups that have concentrated on attacking psychiatry and by implication the other staff working alongside psychiatrists (4). Their activities may have little influence on the actions of psychiatrists, but they serve as a

(1) Rogow (1970) has analysed the way psychiatrists have been portrayed in literature and in the media generally.

(2) Such a list would include drug addiction, various forms of crime and delinquency, problems of childhood and adolescence, alcoholism, organisational and mental health problems at work, race relations, the 'work shy', political militants and dissidents of various sorts. Justifications for such intervention, especially community mental health programmes being provided by such psychiatrists as Caplan (1964).

(3) Quite apart from the well known critics, there have been a series of articles in such papers and magazines as the International Times, Time Out, Oz, Red Rat, etc.

(4) The scientologists have been the most vociferous in their attacks, their literature containing much of the imagery that was complained of by Tuke in the last century. Also the Star Campaign, People Not Psychiatry, the Philadelphia Association have attacked psychiatry from various angles.

reminder that psychiatry has yet to win full public approval for itself. That some psychiatrists are concerned about the accusations made against them, can be seen in the comments of such leading psychiatrists as Sir Martin Roth (1973), that

> "The anti medical critique of psychiatry represents one approach within a wider movement that has assumed international proportions and adopts a critical and derogatory stance towards psychiatry's methods, aims and social role; it is anti medical, anti therapeutic, anti institutional and anti scientific either by expressed aim or implicitly through the dogmatic, horatory, diffuse, and inconsistent character of its utterances" (p.373).

Roth goes on to give a short history of psychiatric progress in which he lists how, in the past, schizophrenics were thrown into prison, and, 'those with dementia were burned at the stake as witches'. However,

> "The progress of science has been achieved through the substitution of rational concepts for beliefs enforced with moral sanctions demanding acts, we now repudiate with repugnance. The recent advance of psychiatry has conformed to this pattern" (p.375).

Such a view of 'psychiatric progress' has been challenged, most notably by Foucault (1965) who has pointed out how changing conceptions of madness have been brought about through changing social, economic and cultural conditions. Mechanistic explanations, and the conception of madness as being like an 'illness' arose at a particular social historical time (1). There is no necessary reason why they should be regarded as being the only possible 'scientific' explanations or the only way of viewing disturbed behaviour, even if some psychiatrists would like to think that they have a near monopoly of science and reason over these matters.

In conclusion it may be noted that while psychiatrists have become

(1) Sarbin (1967), Szasz (1970).

increasingly accepted by other medical specialists, they still lack a proven and efficacious set of techniques, and body of knowledge with which to treat mental illness. Although some psychiatrists might like to believe that their ascendancy over the other occupations, has been due to a form of 'technological determinacy' stemming from their superior knowledge, their current dominance can best be understood by seeing it as a social formation that was created at a time when there were few alternatives. One task of the subsequent chapters is to examine how this dominance continues to be perpetuated.

Clinical Psychologists

In many respects clinical psychologists are a more homogeneous and clearly identifiable group than either psychiatrists or social workers. As will become apparent, the 'professionalisation' of clinical psychology has had the effect of making them a more distinct group from the outside, even if there is a considerable amount of uncertainty among themselves as to 'who they are' and 'what they should be doing'. If nothing else, clinical psychologists are a highly self-conscious group, if the recent spate of publications about the future of the occupation and its aims are anything to go by. A Government inquiry is at present looking into the role and function of clinical psychologists (1). The pressure for this inquiry came largely from the psychologists themselves, and it reflects the general sense existing among clinical psychologists, that their occupation is facing some sort of watershed. At present it is not clear how clinical psychologists will fit into the

(1) Under the Chairmanship of Threthowan.

reorganised health services, and while some believe they will strengthen their position in the new structure, others believe it may be weakened. As one recent writer noted,

> "We may well find ourselves 'directly accountable to consultant psychiatrists' ... in other words statutory lackeys instead of unwilling and informal handmaidens of psychiatry (at present we are accountable to Hospital Management Committees, not to the doctors)" (Smail, 1973, p.213).

Among clinical psychologists themselves, there is a generally held belief that their occupation came into being with the National Health Service (Smail, 1973, Dabbs, 1972). They were indeed 'recognised' then by the title of clinical psychologist, as was demonstrated by the Whitley Council's (PTA Circular 126) use of the term. However, it would appear that a handful of psychologists were working in mental hospitals for some years prior to the NHS Act and that many others were working in other mental health fields (1). Hetherington (1969) has claimed the appointment of J C Raven to the post of research psychologist at the Crighton Royal Hospital in 1943, 'was the first of its kind in any mental hospital anywhere in Britain' (p.303). But, some doubt must be cast upon this assertion as in the same year a committee was formed of psychologists working in mental health services (Hearnshaw, 1969). Out of this committee, there developed the beginnings of what is now known as the Division of Clinical Psychology. This division was created in 1966 and has considerable autonomy from the parent British Psychological

(1) Especially within the Child Guidance Clinics. According to Hearnshaw (1964) the impetus behind the CGC movement was psychological rather than medical. He notes the influence of Burt's recommendations, for the starting of psychological clinics, made in an appendix to the 1925 edition of the Young Delinquent. (See p.110 for note on the origins of Child Guidance Clinics at the end of the chapter.)

Society (1). It is the professional association of clinical psychologists and as such has been largely responsible for the recent moves to fully professionalise clinical psychology. Before considering these moves, a few further points need to be made about the recent history of the occupation.

As already noted, there is some confusion as to the precise origins of the specialty. It could be traced back to the visits of Galton to Hanwell in order to carry out certain psychometric tests upon the inmates. Certainly, the work of the majority of clinical psychologists employed in the NHS appears to have been in the tradition of Galton. More specifically, Hearnshaw (1969) has claimed that psychologists began to apply their knowledge in the area of mental illness in the early part of this century. The biggest impetus to this work, being the First World War and the problem of 'shell shock' and war neuroses. According to Hearnshaw the involvement of leading psychologists in this work was extended and developed with the setting up of the Tavistock Clinic in 1920, where various psychotherapeutic methods were developed for the treatment of neurosis (2). The development of Child Guidance Clinics in the inter war period has already been noted. During this period some psychologists, after in effect becoming psychotherapists

(1) As the BPS is a largely academic society, while the DCP is mainly concerned with the professional problems of applied psychologists - there have been certain tensions and conflicts between the two (see Rawlings, 1967).

(2) Dicks (1970) does not share this view. He has noted that the Tavistock Clinic did not employ a psychologist in its early days, even though some psychiatrists were using psychological tests. The first clinical psychologist was appointed in 1928.

first, became more involved with the treatment of mental illness. However, it was war time conditions that once again provided the impetus for the expansion of psychology in general, as well as its clinical applications. White (1972) has attributed the Veterans Administration with not only introducing psychologists into the United States armed forces, but also influencing their acceptance into the British armed services. Such work was initially concerned with identifying signs of stress and incipient mental illness among pilots and other combat personnel (1). Having demonstrated the value of psychometric techniques in this area, psychologists were then to extend into other areas of civilian life and in particular into the emerging national health services (2). Significantly this work was in the experimental empiricist tradition of British psychology in general, and it was on these terms that clinical psychology appears to have been acceptable to the medical profession, when they took up posts in mental hospitals in the post war period. This period saw a rapid creation of jobs for clinical psychologists within the NHS and saw what Hearnshaw (1969) has described as the "creation of a virtually new profession of clinical psychology".

The growth of this 'new profession' can be demonstrated quite simply by pointing to the existence of an estimated 600 clinical psychologists in the country. (Kear Colwell (1972)). Until recently there were far more vacancies for clinical psychologists of all grades than there were applicants, but the popularity of this specialty among psychology

(1) The Report of an Expert Committee on Psychologists and Psychiatrists in the Services (HMSO, 1947) does not however make any reference to the Veterans Administration.

(2) Flugel (1951) has provided an account of the way the role was extended.

graduates appears to be rising (1). This new-found enthusiasm for the specialty may, however, be short lived among the new recruits. A recent study by Kear Coldwell (1972) of the job movements of clinical psychologists between the years 1967-1970 has revealed that over a third of all psychologists in the NHS (36.7%) changed their jobs during this period, and nearly a half of these (47%) left the NHS altogether. The possible reasons that Kear Coldwell gives for this "high level of discontent with the profession of clinical psychology as it is practiced within the NHS" (p.27) will be noted further on. Before doing so, it is necessary to point to the associational developments that have inclined Rawlings (1967), for example, to claim that clinical psychology has been recognised as a profession. It is relevant to do so, for much of the discontent among clinical psychologists within the NHS, is allegedly due to limitations that prevent psychologists making a professional contribution (White, 1972, Smail, 1973). In other words there appears to be a contradiction between beliefs that psychologists hold of themselves as 'professional people' and the opportunities to be professional within the present NHS structure.

As with social work, the movement of clinical psychology through the 'natural history' of professionalisation can be clearly demonstrated. From the outset clinical psychology has had a knowledge and training base within the universities and has thus not only derived status from this fact, but also autonomy over its training courses (2). Along with the

(1) According to Shapiro (1969) there were 150 vacant posts, out of a total of 550 established posts for clinical psychologists in 1968. White (1972) claims there are now 5 applicants for every post-graduate training place.

(2) Although it should be noted that it is only recently that some of these courses have been run from <u>outside</u> of psychiatry departments (see Dabbs, 1972).

Committee of Psychologists in the Mental Health Service that was formed in 1943, a Committee was established to oversee "the standards of professional education and knowledge and the professional conduct of members" working in applied fields (Rawlings, 1967). Thus, for some time, control has been exerted over members in an attempt to control who can or cannot be a 'psychologist'. At the present time there are committees of the Division of Clinical Psychology drawing up recommendations upon a 'Code of Professional Conduct', and upon 'Registration' (1). In 1965, the BPS was granted a Royal Charter, which, according to Hearnshaw (1969), "gave it a stamp of approval to its aims and activities, and entitles it, if it cares to exercise them, the rights to carry out certain regulatory functions within the profession of psychology". The all graduate entry to the occupation, and the length of the training, would place clinical psychology towards the professional end of a professional - non professional continuum. According to such measures of professionalisation the theoretical knowledge base, derived from experimental psychology and its service orientation would also place it in the 'likely to be professional' category, even if it has not yet developed all the other attributes. It is important to note the associational developments within clinical psychology in recent years, because by so doing, it is possible to illustrate how certain members of the occupation are seeking to make themselves like the established professions and thus secure a recognised mandate for themselves (2).

(1) There has been a continuing debate among psychologists over the merits of registration - see Denburg (1969), while the Foster Report (1971) call for the registration of psychotherapists has led many psychologists to call for renewed efforts in this direction.

(2) The proposed Code of Professional Conduct contains the following statement, that illustrates such claims, "A psychologist recognizes specific professional skills which he is best qualified to exercise in the interests of the public, the individual and the profession. It is incumbent upon the psychologist to protect these interests".

At the same time, the problem of analysing 'professionalisation' in these trait theory terms, can be illustrated by posing the acquisition of attributes on the one hand, with the degree of autonomy and control granted to clinical psychologists in their working situations. For, to return to the point made earlier about the high turnover of psychologists within the NHS, there is evident dissatisfaction with the role that they are currently performing. In other words, it would appear that in the actual institutional settings in which the majority of clinical psychologists seek to use their 'professional skills', that they lack the autonomy to determine how they will use such skills. Thus any adequate theory of professionalisation must look beyond the 'form' that can be developed without necessarily encountering opposition from possible contenders, to the 'substance' that lies beneath the rhetoric of presidential addresses or codes to professional conduct. In Chapter 2 it was observed that none of the mental health occupations possessed the 'distinct body of knowledge' that professions are held to require. Many psychologists might disagree with this statement and thus it is necessary to examine the main ways in which they have developed their expertise.

Recent discussions of the role and work of clinical psychologists nearly always mention four main areas. These are assessment, treatment, (or as Shapiro (1969) terms it, 'modification'), research and teaching (though this is not always mentioned). Having presented such a list, the point is usually made that it is only in recent years that clinical psychologists have taken up therapy. In one recent discussion of this change (Dabbs, 1972) it was claimed that "within a matter of the last twelve months a number of clinical psychologists have become actively involved in psychotherapy". Other commentators have, however, traced the involvement of psychologists in therapy to the 1930's, though as

Gwynne Jones has noted, "During the early years most clinical psychologists, apart from the professionally distinct group of child psychotherapists, tended to avoid involvement in psychotherapy" (1969, p.22) (1). For Gwynne Jones as for many others it has been "the explosive growth of interest in behaviour therapy" that has brought clinical psychologists into the world of therapy. For many psychologists, such as Ingham (1961), behaviour therapy and the application of learning theory on a large scale through 'token economy' principles, provides a natural extension of their diagnostic skills and their knowledge of normal and abnormal psychology. In other words, many clinical psychologists are increasingly claiming to be 'applied scientists' (2). Confident in the efficacy of this approach many clinical psychologists are now claiming that they should replace doctors as the profession to be in charge of the treatment and rehabilitation of certain groups of patients (3).

(1) It is significant that this group of psychologists who were applying psychoanalytic principles were distinct from the main body of clinical psychologists. This reflects the dominance of the experimental approach within British psychology in general, and its lack of receptiveness to psychodynamic ideas.

(2) Hawks (1971) has suggested that Shapiro (1969) and Eysenck (1973) are the best known advocates of this view.

(3) See the BPS memorandum to the DHSS upon the Report of the Committee of Inquiry into Whittingham Hospital, paragraph 6, "It is gradually becoming more widely recognised that the major problems of psychiatric and subnormal patients are not medical but social learning problems. It follows that those specifically trained in behavioural sciences are the ones who would be given the responsibility of organising active rehabilitation schemes".

Such developments have not gone without opposition within clinical psychology itself. There would appear to be some psychologists who are still committed to view that diagnostic assessment is their primary activity. Some have been seeking to extend this role to a wider range of problems than those encountered in an ordinary mental hospital. So as to spread their services more widely Miller (1968) and Peck and Gathercole (1968) have advocated the use of automated assessment techniques. Others have sought to establish the position of 'assessment assistant' so as to relieve themselves of the more routine aspects of this work. Significantly, there appears to be reluctance on the part of some psychologists to relinquish control over the only activity over which they can claim certain monopolistic rights (1). The main opposition, however, to the development of behaviour therapy as the principal technique upon which to expand the role of the clinical psychologist, has come not so much from those committed to the traditional assessment role, but more from those involved with other, particularly psychoanalytically inclined, forms of therapy. Perhaps 'opposition' is too strong a word to use to describe what may more appropriately be described as a tension or conflict of approach. In the past, and to the present day, there has been a public and frequently acrimonious debate between the advocates of a psychodynamic as opposed to a behaviourist approach to the study, and treatment, of neurotic and personality

(1) In the Division of Clinical Psychology Newsletter, No. 9 , 1972 some concern was expressed over this.

problems (1). The controversy still finds expression in various journals and conferences, and the 'opposition' that one has for the other can be seen most clearly in the dominance of one or the other approaches in certain training centres. However, there is also evidence that many practicing clinical psychologists accommodate both approaches in their work, and as such, are seeking to extend their role in a way that would include both greater involvement in psychotherapy and also running rehabilitation programmes upon a 'token economy' schemes for example (2).

Some psychologists believe that, in a more general form, there has been a conflict between those who see themselves as healers or helpers and those that see themselves as applied scientists, throughout the history of the profession (Claridge and Brooks, 1973). In a study of applicants to the Glasgow MSc course in Clinical Psychology, Claridge and Brooks have claimed that a majority of applicants now see clinical psychology as a helping, practical profession as opposed to a scientific one (3). They point out how their findings suggest early evidence for the later role confusion and job dissatisfaction likely to be experienced by those who succeed in entering clinical psychology

(1) For example, that between Eysenck (1969) and Guntrip (1969).

(2) It may well be that the beginnings of segmentalisation within clinical psychology can be detected in the setting up of the British Association of Behavioural Psychotherapy (4 Feb. 1972) and its 'rival' the Psychology and Psychotherapy Association. Both are concerned to foster the development, dissemination and practice of their distinctive approaches to therapy.

(3) 87% had chosen to enter it because of the possibilities of therapy (12% for research) although 67% thought they would also be doing research.

"... he may therefore find himself a highly trained academic caught, without a unique therapeutic contribution to offer, between the two existing major caring professions of medicine and social work, each of which is already carrying out some of the functions he aspires to perform" (p.125) (emphasis as in the original).

As already noted, the recent spate of articles upon the present state of clinical psychology indicate a widespread recognition of the 'role confusion and job dissatisfaction' that Claridge and Brooks refer to (1). Typically, the focus of the dissatisfaction is taken to be the restricted role that psychologists are allowed to play in most mental hospitals. Kear Coldwell (1972), for example, after noting that salary rates are comparable in the NHS with alternative sources of employment, suggests that dissatisfaction stems from four possible areas, 1) the role of the NHS psychologist in the hospital and in particular how this relates to his training, 2) relationships with other professions, eg with medicine, 3) status within the hospital service, 4) communications with senior officials of the hospital service. Others have taken a more historical approach and have located the present trouble with the development of the occupation as 'diagnostic aides' for the medical profession. White (1972) has argued that not only have clinical psychologists been working in the wrong field, but that their concepts and methods have been inappropriate (2). He locates the problem with the

(1) Though 'official' views upon the profession present a rather different picture of it - eg Gwynne Jones (1969).

(2) He believes that most of the problems that a psychologist encounters in a mental hospital are usually 'beyond purely psychological assistance'. Instead psychologists should concentrate on problems that they can solve and which are more amenable to their techniques - such as delinquency and other forms of deviance.

adoption of the rationale and methods of psychometry that he considers to have little relevance to the study of patients' behaviour. Smail (1973) develops this point further to claim that the "raison d'etre upon which clinical psychology was founded has become increasingly discredited" (1). For Smail it is the development of "alternative conceptual tools with which to approach the phenomena of mental disorder" that has led to what he takes to be a rejection of the medical model upon which he claims, traditional clinical psychology, as well as psychiatry, has been based.

Like Kear Colwell, White also asks whether or not clinical psychologists are being inappropriately trained so that they expect too much from the job. He concludes though that it is more a question of their being under-employed, a view that has been echoed by many others (2). While there may be unanimity over this point, there are considerable differences of opinion as to the ways in which psychologists should remedy the problem. Before considering some of the proposals, it is necessary to look a bit further into some of the alleged causes of the dissatisfaction and, in particular, into the question of the relationship of clinical psychology with the medical profession. Smail (1972) believes that psychologists themselves have played a large part in letting themselves be dominated and restricted by the medical profession.

(1) He suggests that not only have some tests been shown to be invalid, but that many others have been standardised on inappropriate populations. In other areas of psychology, there is evidence of a crisis of confidence in the objectivity of assessment techniques. This is especially the case in educational psychology as the controversy over the objectivity of IQ testing has demonstrated (Ryan, 1972).

(2) Smail has suggested that the clinical psychologists dissatisfaction with their status stems from being highly educated, yet being regarded as auxilliaries.

He claims that the approach taken by early founders of clinical psychology, of seeking to advance the scope of their role through personal persuasion of individual psychiatrists, in covert ways that never threatened the authority of the doctors, has led to them being in a position where no one knows what psychologists are capable of doing. While accepting that many psychologists are able to do therapy, research and teaching, he argues that this has only been achieved through 'calculated obsequiousness', and that it has never been established as a right. Smail further believes that the approach of aping rather than competing with the medical profession, and the attempt to

> "gain by stealth a position which we would never gain by storm, has nevertheless led to a position in which in the coming reorganisation of the NHS in 1974, we may well find ourselves 'directly accountable to consultant psychiatrists' (Management Arrangements for the Reorganised Health Service, HMSO, 1970) - in other words, statutory lackeys instead of unwilling and informal handmaidens of psychiatry (at present we are accountable to the Hospital Management Committee not the doctors)" (p.213).

Smail goes on to argue for a complete rejection of the medical model and for

> "clinical psychologists as a profession to organise themselves in a political sense in a way which enables them to make a credible assertion of independence from medicine".

Significantly Smail bases his claim upon the assertion that clinical psychologists now see themselves as being experts

> "in psychological matters within the broad clinical field"

and as

> "possessing a body of knowledge, a conceptual system and a range of techniques appropriate to the field. Primarily his attitude is rational, and he will attempt to justify his beliefs and activities by reference to a scientific tradition. He does not practice his trade through the handing down of authority, nor is he likely to subscribe to a basically and loosely, empirical orientation to his subject" (p.213).

In other words, Smail is making what Jamous and Pelloile (1970) would consider to be a claim for the superiority of technical knowledge over

indeterminate skills.

The more combative approach towards the medical profession finds echoes among other psychologists. However, somewhat significantly many seem more concerned to define themselves out of the area of 'mental illness' rather than seeking to demonstrate the superiority of their knowledge in this area. This is certainly the message of Hawks (1971), who takes a very pessimistic view of all forms of intervention and treatment with all forms of psychiatric illness. He advocates that psychologists be involved with rehabilitation schemes, the selection and training of nursing staff, and in general providing advice upon the many management problems that arise in mental hospitals. Hawks in other words has advocated a near complete abandonment of any attempt to conduct therapy with individual patients. Instead they should be concerned with the 'total health of the environment' affecting the patient. This view is similar to that advocated by White (1972), who believes that to 'resuscitate' clinical psychology, it should only concern itself with problems that only psychology per se can manage. He believes that this will mean leaving the mental hospitals and instead look at other forms of maladaptive behaviour and the settings in which it is treated. Within such settings the focus should be more upon "communication systems and social structures, than with the individual" (p.104). White goes on to argue for a change of title to signify the changed function, the new title being that of 'community psychologist'.

There have been various other suggestions as to how clinical psychologists might make their contribution more worthwhile. Some of these also favour a move away from the close association with psychiatry. Eysenck (1973) has written in favour of psychologists working much more in general hospitals so as to investigate such phenomena as pain, and to

advise on the suitability of patients for certain types of surgery - such as sterilisation, hysterectomy and organ transplants (1). Drewery (1973) has spoken of establishing an area psychological service that would eventually be staffed with one psychologist for every 25,000 people. Where his proposal differs from that of other ones for area psychological services, is his proposal to link psychological clinics to the general practitioner service (2). A general theme running through nearly all such proposals is that clinical psychologists should be concerned with all forms of 'psychological dysfunction' or 'maladaptive behaviour' rather than 'psychiatric illness'. Dabbs (1972) makes this point very clearly and goes on to argue the case for clinical psychologists to take over the education and training of mentally handicapped children (3). Others have referred to the work they can do with the physically disabled, the physically ill and chronically sick (4). Thus, while some psychologists, such as Smail, seek to take over large areas on 'mental illness', there are others who wish to remove themselves from the area of psychiatry altogether. There are others who wish to stay in the mental hospitals, but instead of performing either assessment of various forms of individual therapy, they wish to act as psychological 'consultants', advising upon staff selection and training, undertaking research into

(1) This view has been endorsed by others, eg Drewery (1973), Hetherington (1969).

(2) The other proposals have been more concerned with serving the needs of various hospitals - both psychiatric and general as well as other formal agencies - such as courts and social service departments.

(3) A very clear statement, laying out a claim for the superiority of psychological over medical knowledge has been made by the BPS in a Memorandum (1968).

(4) Mechanic (1969) has noted this development.

problems of ward and hospital management, helping resolve communication difficulties within the hospital and in particular taking charge of the rehabilitation programme within the hospital (1).

Perhaps because of their relatively small numbers and the general public's ignorance of the difference between psychologists and psychiatrists, clinical psychologists have not been the targets of the criticisms that have been levelled both at psychiatrists and social workers. However, from within their own ranks there has been evidence of increasing dissatisfaction and dissent (2). Among other things, many of the dissatisfied have objected to the moves to 'professionalise' their occupation. It may well be that many of these psychologists will define themeselves out of the occupation and thereby provide no hindrance to the ambitions of those who are seeking a register, a code of ethics and effective disciplinary machinery over offending members. Registration and legal controls over the use of the title would require an Act of Parliament, which means that the medical profession, through its influence with members of parliament, could either help or hinder such moves. Unless psychologists can establish themselves in non medical centres, it seems unlikely that the medical profession will welcome the registration and the granting of equal legal protection to another profession working alongside itself.

Clinical psychologists in Britain seem to be some years behind their colleagues in the United States in coming to terms with the problem of

(1) See BPS Memorandum (1971) on this.

(2) This dissatisfaction has found expression in such magazines as Red Rat ('the magazine for radical psychologists') and Humpty Dumpty which was created after disagreements over the editorial policy of Red Rat. There have also been various meetings, and sessions, such as the National Deviancy Conference in York (September 1973) at which clinical psychologists have discussed how to transform and radicalise their occupation.

the prior dominance of the medical profession. This may well be because of the empiricist and experimental tradition in British psychology, that has led to a distrust of dynamic psychology, and thus a reluctance to undertake 'therapy'. The situation would appear to be changing as the recent spate of articles on the theme 'what must be done' has demonstrated. Many of these articles have noted a general lack of certainty over not only the role of clinical psychology but also over its value. Further, the lack of alternative sources of employment (1), other than in centres in which the medical profession is already dominant, has meant that the problems that clinical psychologists face are more acute than those facing social workers.

The 'psychiatric' social worker

The histories of psychiatry and clinical psychology might be complex, but they appear relatively straightforward compared with that of social work. The task is made more complicated because of the recent changes that have taken place in the organisation and structure of social work. The focus of this study is on those mental health occupations that are working within mental hospitals, or are otherwise specialised in dealing with mental patients; however since the re-organisation that followed the Seebohm Report (1968), all social workers might be expected to deal with psychiatric cases along with other clients, even though some

(1) As Kear-Caldwell (1972) has shown many clinical psychologists leave work with mental patients to take up teaching and research posts in Universities. The child guidance clinics being the main non medical source of employment.

specialisation has remained (1). Clearly, a full history of social work with mental patients either inside or outside of mental hospitals, cannot be considered apart from the history of other forms of social work, but for the purposes of this thesis, attention will be directed mainly towards those events that have had a direct bearing on the development of social work with mental patients.

If 'social work' be equated with voluntary work for the moment, then the origin of organised social work in mental hospitals would appear to have been the founding in 1877 of 'The After Care Association for the Female and Friendless Convalescent on Leaving Asylums for the Insane' (2). This period also say the beginnings of social work as a full time paid activity, when the Charity Organising Society began employing young women as secretaries, to investigate claims being made for assistance and charity (3). Within a few years similar ladies were being employed by certain general hospitals in order to vet claims for free medical care. From this original financial function, wider welfare roles developed such as contacting relatives, making arrangements for discharge and charitable assistance. It does not appear, however, that such almoners were employed in the asylums until the 1920's, when the Board of Control began recommending their employment, although the 1913 Mental

(1) The actual processes of admitting patients to mental hospitals under detention orders are still largely administered by the ex-mental welfare officers. The extent to which specialisation has remained will be considered further on.

(2) According to Timms (1964a).

(3) There are several histories on the origins of social work that have analysed the role of the Charity Organising Society such as that of Young and Ashton (1956). Stedman Jones (1971) has recently drawn a connection between the economic crises within capitalism in this period and the role of the C.O.S. in attempting to control the working class. The Settlement Movement that marks the start of 'community' social work, can be seen to have a similar origin.

Deficiency Act had provided an impetus for voluntary work. As Timms (1964a) has pointed out, the Board of Control justified their use in terms of the practical assistance they could render to the doctors. In particular, it was argued that they could collect much more detailed information on the patient's background and home conditions, than a doctor could working on his own. But from the point of view of the social workers, they were quick to stress how this work required training, and that it was more than "sympathy and common sense, it is a skill to be communicated, a technique to be acquired" (1).

Such calls for training, were in part being met by the start, in 1929, of a course for Psychiatric Social Workers, at the London School of Economics (2). The Board of Control repeatedly recommended the employment of psychiatric social workers in mental hospitals, but the supply was small, and those that were trained appeared to prefer working in the recently established Child Guidance Clinics (Timms 1964a). This was hardly surprising in view of the way the beginnings of the LSE Course and the occupation of 'psychiatric social work' was intimately tied up with founding of child guidance clinics (3). The limited supply of Psychiatric Social Workers, at a time when mental hospitals were becoming more involved with discharge and after care of patients, meant that many started employing untrained women as social workers, and gave them the

(1) Evelyn Fox speaking at a conference organised by the Board of Control, quoted by Kathleen Jones (1972).

(2) Training for social workers had started in both London and Liverpool Universities before the First World War. The almoners being the first branch of social work to organise themselves in order to establish a qualification.

(3) As the start of the child guidance clinics has a bearing on both the origins of clinical psychology and psychiatric social work it is dealt with separately at the end of this chapter (pp. 110-12).

title of 'psychiatric social worker'. Timms has pointed out how the Association of Psychiatric Social Workers, founded in 1930, was faced with the perennial problem that not only was the title Psychiatric Social Worker employed by trained medical social workers in mental hospitals, but also by the completely untrained. In time the problem of titles was partially resolved, and the establishing of a register in 1960 meant the qualified could be distinguished from the unqualified (1).

Quite apart from the problem of the misuse of the title, it appears that psychiatric social workers themselves were divided as to the meaning of the title and further there were differences of opinion over the relationship of their skills to those of other social workers. Timms has drawn attention to these problems and has suggested that there was a dualism between bringing a psychiatric view point into social work and that of social work into psychiatry. At the same time many psychiatric social workers felt they had been trained for and were skilled at 'therapy', whereas the training of other social workers only equipped them for welfare work. The problem was complicated by the fact that in many mental hospitals, all types of social worker were doing the same work, and further the introduction of psychiatric social workers into mental hospitals was justified in the same terms as the introduction of other social workers, namely the assistance that they could give to the psychiatrists.

It seems from the outset that those who chose to work in mental hospitals were faced with more problems than those who worked in the

(1) The question of titles and status became more important with the founding of the National Health Service. The Younghusband Report (1959) recommended that the title be restricted to members of the association.

expanding child guidance clinics. The close association of psychiatric social workers with these centres in which the influence of psychoanalytic ideas was most marked, enabled them to not only develop their skills as therapists, but also it meant that as an occupation psychiatric social work developed largely outside the medical contexts. This statement needs immediate qualification, in so far as psychiatrists were often in charge of such clinics, but at least the social workers had been involved from the start of the clinics, whereas in the mental hospitals they came in as outsiders, long after the medical and nursing professions. In the early days it is evident that psychiatric and other social workers encountered a mixed reception from the other staff, and as Timms (1964a) has observed, "... the role of the psychiatric social worker in the mental hospital developed in response to the individual demands on each particular institution" (p.112). Not only was there a wide range of possible work for the psychiatric social worker to carry out, but also marked differences of opinion among the psychiatrists as to their expectations of her role. Initially the work revolved around taking social histories and working with relatives, but by the 1950's many were working directly with patients (1). The opportunities for the psychiatric social worker to become involved with patients expanded in the post war period in those hospitals that adopted a 'therapeutic community' approach, while the increasing acceptance of psychotherapy and group therapy in mental hospitals, enabled the psychiatric social worker to become more involved in various forms of therapy. The expansion of facilities and numbers of staff with the creation of the NHS, coupled with official blessing to the idea of 'team work', brought increasing acceptance to the presence of social workers in hospitals (2). But

(1) Timms has suggested that the desire to work with patients stemmed in part from the higher status and intrinsic rewards to be gained from such work, but also because of the additional benefits at work such as earlier retirement.

(2) Further on attention is drawn to the importance attached to team work from the start of the child guidance clinics.

as Timms has noted, such involvement raised a question mark over the relationships of psychiatric social workers to psychiatrists, as he points out

> "Is the work of the psychiatric social worker auxilliary to that of the psychiatrist or does she follow an approach or follow some skill that is different from that of the psychiatrist?" (p.117).

It appears that while some sections of the medical profession welcomed the advent of social workers of all kinds, there were others who were more resistant if not outrightly hostile. Timms has recorded the efforts of certain members of the medical profession to persuade the Association of Psychiatric Social Workers to seek registration as a Medical Auxilliary Service. The A.P.S.W. resisted such pressures on several occasions, and its success at fighting off such attempts to have it officially defined as an auxilliary service was demonstrated when psychiatric and medical social workers were granted considerable organisational autonomy within the NHS. But the problem of the relationship of psychiatric social work to the medical profession did not end there, for it would seem that while psychiatric social workers had resisted attempts to have themselves officially defined as auxilliaries, the majority of them believed that it was appropriate that they should work, if not under immediate medical direction, then at least in association with psychiatrists. As Timms (1964a) has pointed out, the early grandiose claims that all the mental health services should be staffed entirely by trained social workers were gradually dropped, as it was realised that the area in which psychiatric social work had developed its knowledge and skills was largely restricted to the treatment of intelligent, neurotic patients. Indeed, it would seem that from the outset, psychiatric social workers chose to work in settings where they have

encountered clients who were more amenable to non medical forms of therapy, rather than seeking to challenge the medical profession in mental hospital contexts (1).

Prior to the unification of the various social work specialisms in April 1970, when the British Association of Social Workers was formed, psychiatric social workers had often been regarded as the elite of the social work profession. This elite position being partly due to the longer training and qualifications demanded of them, but also perhaps because many psychiatric social workers took up teaching posts during the expansion of training courses in the 1950's and 60's. This has meant that their influence over the rest of social work has been greater than their numbers might suggest, and may in part account for the dominance of psychoanalytic theories of human development on most social work courses (2). This point will be taken up again further on, meanwhile the limited numbers of psychiatric social workers being produced by the four centres of training and the ensuing shortage of them had been noted by the McKintosh Report (1951) and again by the Younghusband Report (1959) (3). The solution that was suggested to the general shortage of trained social workers, was the creation of generic training courses and three grades of social worker depending on their qualifications. It appears from

(1964a)

(1) Timms/has shown how in 1937 there were almost twice as many psychiatric social workers in mental hospitals to child guidance clinics, that is 43 to 24, but by 1961 there were 193 in mental hospitals, 219 in child guidance clinics and 65 in local authorities.

(2) This can also be shown through the greater readiness of psychiatric social workers in the past to contribute to the growing literature of social work, although they, like most other social workers, rarely carried out research. See Timms (1964a) Chapter 7.

(3) The shortage being exacerbated by the concentration of social workers in the South East of England.

Timms' account of the response of the A.P.S.W. to such developments, that while the lowered standards of training were reluctantly accepted, there were conflicts among psychiatric social workers as to the desirability of generic training. This conflict being one of the many that existed between the various elements and sections within the A.P.S.W. In time the A.P.S.W. became an advocate of the unification of social work, and brought about its own dissolution in November 1969 (1).

At the time of the Seebohm Report (1968), the mental health services appeared on the one hand to be employing some of the most highly qualified social workers, but on the other to be employing a far higher proportion of untrained workers than some other branches of social work . In recent years many previously untrained social workers have taken courses to equip themselves with basic qualifications, but the problem still remains that for some time to come social workers will not have shared the same educational experiences. In the mental health field such differences have been most marked in the local authority mental health departments in which both psychiatric social workers and mental welfare officers have been employed. The problems that such differences have created for the professionalisation of social work will be considered below. Before doing this, a few further points can be made about recent developments that have affected the position of social workers that deal with mental patients.

(1) There have been subsequent attempts to maintain a distinct identity for 'psychotherapist' social workers. A circular was sent to all members of A.P.S.W. register in 1971 about this.

As yet very little has been said about the employment of local authority social workers. This is mainly because the focus of this study is largely upon staff working within mental hospitals. However, one of the recommendations of the Seebohm Report that has yet to be fully implemented is that all social workers working in hospitals be employed by the local authority Social Service Departments (1). More importantly than this though, has been the controversy that has surrounded the Seebohm Report's recommendation that all social workers, including those that had previously come under the direction of the Medical Officer of Health, be employed in unified departments of social service (2). This removal of local authority mental health services from medical direction was bitterly opposed by some sections of the medical profession, and while most doctors appear to be reconciled to this loss, there have been repeated calls for the re-establishing of medical control over the mental health social workers, at recent British Medical Association conferences (3). The Seebohm Report itself recommended the appointment of a psychiatrist to act as a consultant to social workers on matters of mental

(1) Much of the report is concerned with the problems posed by those services such as mental health social work that are necessarily involved with the health services. The report concluded that these should come under the Departments of Social Service because 1) mental illness triggers off social problems and disabilities within families, while it is the social worker who should have responsibility for the whole family, 2) not to do so would be to continue the segregation of the mentally ill with separate services in the community.

(2) At one point a group called the Seebohm Implementation Action Group was formed with the support of the A.P.S.W. and the Society of Mental Welfare Officers, to fight what was regarded as a take over bid by the medical officers of health. A boycott of those boroughs that appointed their Medical Officers of Health as Directors of Social Services was called for and much concern was expressed in letters to New Society (23.1.69, 13.3.69, 1.5.69, 4.9.69 following an article on this in the issue of 9.1.69), and also in the social work journals, such as Social Work Today.

(3) For reports on such demands see the Guardian 20.7.72 and 6.6.73. The recent concern over 'battered babies' has also provoked demands for more medical supervision of the social services - Guardian 15.11.73 Smith, S. and Noble (1973).

illness, but many psychiatrists appear to believe that they should have more than an advisory role to play (1).

The Seebohm Report and the resultant Social Services Act in 1970 have been described as providing a 'Charter for Social Work' by Heraud (1972), while

> "The formation of the British Association of Social Workers in April 1970 marked a milestone in the history of the social work profession in Britain" (Heraud, 1971).

These views of an outside sociologist, have been echoed by many social workers when commenting on the increasing professionalisation of social work. The question 'Is social work a profession?' has frequently been asked by both social workers and outsiders alike, and as yet there is no unanimous answer. Some sociologists such as Goode (1969) have seen fit to declare that social work is soon to join the ranks of the professions, but others such as Toren (1969) consider that social work will remain a semi-profession. Social workers themselves appear more than usually concerned about this question and those that wish to answer in the affirmative, frequently refer to Greenwood (1957) who had concluded that social work was on the road to becoming a profession (2). Social work educators, however, are generally quick to point out how uncertain and provisional most of the knowledge is that they teach social work students (3). Most other personal service occupations have to train their students

(1) See, Memorandum by the R.M.P.A. and the Society of Medical Officers of Health on the Seebohm Committee's Report, published in the British Journal of Psychiatry (1969).

(2) An example being Blackey (1968).

(3) While making such provisions, there are often elaborate accounts given of the various approaches, techniques and methods that social workers employ, as if these are of proven validity.

for 'uncertainty' as Fox (1959) has pointed out with reference to medicine, but social work students are faced with the further problem that their work will encompass so many different fields and so many disciplines, that it is difficult to identify just where their unique contribution lies (1). The social sciences are often referred to as providing the knowledge base of social work, but as Hardy (1970) has pointed out, this knowledge is itself provisional and subject to continuing controversy. Stevenson (1971) has also reflected this view and has called for social workers to develop their own knowledge, but as Timms (1971) has observed, social workers have been slow to carry out research into the effectiveness their own methods, and thus can hardly as yet claim to have developed a distinct body of knowledge. While the educators may demand more theoretical knowledge, it appears that many practitioners consider such knowledge to be irrelevant to their working situations (2). Such divisions of opinion themselves being reflections of a conflict that has always existed within social work, between those who have stressed the need for academic training and those who have stressed the role of practical experience as the only way to develop a sound judgement and the necessary intuition based ability (3).

Quite apart from the debate over the nature of social work knowledge, there are differences of opinion over the best means by which social

(1) Flexner drew attention to this problem in 1915, and since the point has been repeated by Heraud (1971a, 1971b, 1972), Willensky and Lebeaux (1965).

(2) Parkinson, writing in New Society (1970) has given expression to this view and has sparked off many rebuttals in the letters column.

(3) Both Toren (1969) and Meyer (1967) have drawn attention to the history of this conflict.

workers might apply their knowledge. In histories of social work, reference is usually made to the way the early commitment to social reform, associated with a more 'sociological' approach to locating a client's problems with their position in the wider social structure, was replaced in the inter war years with a more psychological approach based on 'casework' (1). In recent years social work has often been equated with casework, however one leading social worker recently commented that "casework is in the process of being discredited as ineffective, too time consuming and expensive" (Daniel, 1969). She went on to observe that many social workers are looking towards social group work and community work as being more effective alternatives. But at the present time, it would still seem that some form of 'casework' is the major activity that social workers claim to be their own. Indeed, Willensky and Lebeaux (1965) have observed that

> "It is so dominant that it is doubtful that there should be such an identifiable entity as social work without it" (p.288).

They were commenting on the American situation,where casework based on psychoanalytic principles developed earlier than in Britain, but even so it would also appear to have become the dominant approach in this country in recent years (2). The problem is though that social workers themselves are divided as to what constitutes casework, as the numerous books and articles on the subject demonstrate. What is clear though is that

(1) Though Lees (1971) has challenged the view that the 'psychiatric deluge' led to social workers abandoning their conern with social reform.

(2) Timms (1964b) has noted the dependence of British social workers on American writings on social casework. His own work like that of Younghusband, McDougall and Huws Jones represents the emergence of more distinctly British approaches to social work theorising. (I am grateful to Mrs Joan Clegg for drawing my attention to this fact.)

casework as practiced in both the United States and Britain, cannot be considered aside from the rise of psychoanalysis, and the different directions that this has taken in both countries. The influence of psychoanalysis was much more immediate and more far reaching in the United States than in Britain, but in both countries, psychoanalytic orthodoxies and reappraisals have been 'passed down the line' to caseworkers, as Halmos (1965) has demonstrated. Further, bearing in mind the varied statutory obligations, and the way certain requirements arise from the particular agency function, then 'casework' has become a term to describe no single set of techniques, but a broadly based approach to understanding and dealing with a client's problems. However, the very similarity of this approach with that employed by other counsellors and its reliance on some of the same techniques as used in psychotherapy, has meant that social workers have not been able to lay exclusive claims to its practice (1). Its close association with psychoanalysis has also meant that the credibility of social work has been undermined where psychoanalytic thinking has been attacked (2). Further, as Halmos has pointed out, many social workers as well as other counsellors, reject the idea that they are applied scientists using techniques derived from the scientific knowledge of psychoanalysis, and instead assert that therapy is only possible if there is empathy, love and trust between the client and therapist.

(1) Prins and Whyte (1972) for example suggest that psychotherapy and casework are at times almost indistinguishable.

(2) Not all social workers would wish to be associated with psychoanalysis as the major source of therapeutic approaches, Jehu (1972) and Graham (1971) among others have been advocating the application of certain ideas from behaviour therapy.

With reference to the American situation, Toren (1969) has suggested that

> "The tendency of the social worker to identify his tasks as casework instead of public welfare is part of the drive for professionalisation" (p.164).

It would seem that in this country also, those social workers who have articulated the demand to be more professional, have sought to dissociate themselves from 'welfare work', which they have seen as involving more bureaucratic control, and thus less professional 'autonomy'. However, in recent years casework itself has been increasingly attacked as being less in the interests of the social workers clients, than the giving of more material forms of assistance (1). Such attacks point to the way that social work, like psychiatry provoke public debate and controversy. Whether favourable or otherwise, such comment demonstrates that social workers have yet to win the public recognition that tends to elevate certain occupations beyond such scrutiny and criticism. Heraud (1972), among others, has suggested that the relationship of social work to the State, means that there are inevitable conflicts of interest between the social worker and her client that undermine the possibility for a 'professional' relationship.

Quite apart from casework, the other two main areas in which social workers apply themselves are group work and community work, or 'social action' as it is sometimes called. Both of these areas have been regarded as specialisms for some time in the United States, but it is only in

(1) Wooton (1959, 1960) has become the best known critic, having charged caseworkers with making global claims that are both value laden and pseudoscientific, and, moreover, she believes that casework serves inherently conservative functions by locating the cause of an individual's problems with his personality, rather than his social situation. This view has been echoed by Sinfield (1969), Laurie (1970) and also in various issues of Case Con.

recent years that they have emerged as such in this country. Again there are problems of definition, but it could be argued that both approaches have existed within social work since its beginnings in the last century (1). As with casework, both activities are also carried out by other occupations and laymen, and thus cannot be seen as involving skills that are distinct to social workers. Group work today, like casework, has tended to become associated with certain psychodynamic ideas and concepts, and thus it has developed largely in psychiatric settings (2). There are courses in group work, but these are open to various occupations, while the encounter group variants of it have developed completely outside the control of any of the established occupations. A survey of social workers who claimed to practice group work showed that many had received no training in it, or had read very little about it (Barr, 1966), while the controversy that surrounded the setting up of the Association of Group Workers, illustrated how there is very little agreement as to the skills, training or qualities required of group workers (3).

It often appears that social workers are only distinct from lay men because they are employed full time at certain activities. Nowhere is this more clearly demonstrated than in the field of community work. The range of problems to be covered by such work is vast, while the

(1) This is particularly the case with community work - as the early Settlements can be considered to be the beginnings of this approach, Inglis (1963). Konopka (1972) has traced the origins of group work in the United States to the recreation movement in the 1900's. In this country, youth clubs and related activities might be considered as group work.

(2) Group work appears to have arisen in psychiatric hospitals, during and immediately after the Second World War. Maxwell Jones (1952) was one of the pioneers of this approach, but it was also associated with the early T-groups that were pioneered by Bion (1961), although there are social workers who have written about it (Douglas, 1970).

(3) This controversy was reported in part in the letters column of New Society (14.11.68, 21.11.68 and 9.12.68).

proven techniques for effective action are virtually non existent. If the social worker is determined to pursue the interests of her clients, then this will almost inevitably lead to political action that will be unacceptable to her employer, and thus she may have no choice but to resign (1). Clearly some social workers are able to provide useful assistance to their clients, through support to tenants associations and other community action groups, but such work is also carried out by political activists, and thus can hardly provide the base from which to build a 'profession' (2).

It may well be that the search that many young social workers are making for an alternative approach to their work, to be based much upon a reassertion of the importance of material aid for material problems, will mean new forms of association that are different to those found among the established professions. The emergency of the Association of Community Workers, with its aims to bring together all community workers irrespective of their training, qualifications or occupations, may indicate a tendancy to 'de-professionalise', according to Heraud (1971) (3). Social workers in Britain, unlike their counterparts in the United

(1) One incident that led to such 'resignations' having been reported in The Guardian, 10.2.72.

(2) Poppleston (1971) has provided a detailed account of such dilemmas.

(3) This has also been noted by Epstein (1970) and Feldstein (1971) in the United States. The recent 'radicalisation' of social work has taken various directions, including refusals to 'split homeless families (Guardian 8.12.72), to implement the Immigration Bill (Guardian 22.7.71), and general opposition to 'welfare cuts' (New Society 11.11.71), as well as militant action in demand for higher pay for carrying out special duties (Guardian 12.5.71 and 20.5.71, New Society 7.10.71, Guardian 4.10.72). A recent study by Erlich and Tropman (1973) in the United States has shown social work students to be more militant than other students. Mott and Goldie (1971) have also found the same in this country.

States, have not had to administer routine welfare benefits. This has freed them to develop their interests in other directions. However, Wooton (1959) has argued that the salvation of social work as a profession would be fore it to concentrate on the administration of the social service. As she puts it,

> "This middleman function is now so expert a service as to qualify for professional status in its own right" (p.265).

There are others who would disagree, and echo Flexner's belief that such a liaison function would leave social work with nothing unique to contribute. However, it does seem that in recent years that there has been a reassertion of the 'social' in social work, although those social workers who are keenest to professionalise would also seem to be the keenest to divest themselves of these activities. But for such social workers there is the problem that Heraud (1972) has noted

> "It is doubtful that social work knowledge claims sufficient respect from other professions to be an entirely sound basis for professionalisation" (p.72).

Reference has already been made to the way that there have been frequent assessments of the state of professionalisation among social workers. The most recent, detailed consideration of this question, Heraud (1972) has noted how far social work in Britain has progressed along the stages of professionalisation, as identified by Willensky (1964). He concludes that in such areas as training, the standardisation of qualifications, the development of a unified national association, and gaining of greater autonomy over their own affairs, that social work is becoming more like a profession. However, at the same time he notes that the process is incomplete. Social workers lack a distinct, theoretically based and empirically validated body of knowledge. Further, they are not always in control of the application of the knowledge they have, as

a consequence of working in complex organisations over which they have no ultimate control. He also notes how social workers have deserted their original mission of being concerned with the 'social', while their latent social control functions undermine their service ideal (1).

A few further points cane also be added. Social work is thought of as being a predominantly female occupation, and thus enjoys a lower status than comparable male occupations (2). Quite apart from the lower status, the women within such occupations are likely to take a different orientation towards their work and may be more likely to accept bureaucratic control. The conflicts that arise between raising a family and their work often forces women to accept a lower status at work (3). It has also been noted how both in the United States and Britain, social work has drawn its new recruits increasingly from the lower middle and upper working classes (4). Social work may thus become like primary school teaching, a means of upward social mobility. For this reason, it is likely to reflect the social marginality of its members, when compared with the more established professions that draw their recruits from the upper middle classes. The shorter training periods and older average age

(1) But for Goode (1969) it is the service basis of social work that justifies the placing of social work towards the professional end of a hypothetica professional - non-professional continuum.

(2) In factin the higher reaches of the occupation, men predominate, and indeed they may predominate throughout. There is a problem of which jobs to define as social work, but Heraud (1972) has interpreted the 1961 census as showing social workers to be 53% male. Other 'female' occupations being nursing, midwives, primary school teachers, and librarians. Goode (1966) has drawn attention to the problems of this latter group.

(3) Foggarty et al (1971) have recently documented the range of the problems facing women graduates who seek to have a career and raise a family. A further relevant study being that by Simpson and Simpson (1969).

(4) In Heraud's (1972) study on social work students, he found that 54.1% of the men and 25.1% of the women in his technical college sample, came from manual backgrounds, whereas among the university students, 23% of all students came from such backgrounds.

of entry to the occupation may also inhibit the development of a distinct occupational culture and social work identity (1). Further, the association of social work with low status clients may also affect the low esteem given to social workers by the wider community (2). Social workers may occupy a position of power over their clients, in terms of their control over desired resources, but it is far from clear that their clients willingly defer to them. As Heraud (1971a) has noted, "caseworkers are not regarded by their clients as possessing exclusive jurisdiction in personal problems". The study by Mayer and Timms (1970) has also drawn attention to the reluctance of many clients to go to social work agencies, and their dissatisfaction (as well as satisfaction) with the service they received. Indeed, it would appear that there is widespread public ignorance of who social workers are, or what their function is (3). The Seebohm Report may have demonstrated State recognition for the importance of social work, but in certain important respects such as the right to confidentiality, social workers lack the legal protection of the more established professions (4).

It may well be that the members of the Association of Psychiatric

(1) Heraud (1972) deals with this question in some detail, and shows how of the older students many were unwilling to adopt a social work identity, unless they had already thought of themselves in these terms before taking the course.

(2) In this respect they are in a similar position to psychiatrists, and as Legatt (1970) has pointed out, to primary school teachers.

(3) For example a study by Timms (1962), of public attitudes towards social work, found that 75% of his sample had not heard of Psychiatric Social Workers, while 80% could not say what they did.

(4) In Social Work Today (March, 1971) there is a discussion of this problem.

Social Workers, before its dissolution, were among the most 'professional' of social workers, and thus in a stronger position in relation to other occupations. But they now share the same fate as other social workers, who cannot be regarded as being as qualified to deal with mental patients as the psychiatric social workers were. This brief account of the development of 'psychiatric' social work has attempted to draw attention to certain features of their past development and present position. The focus inevitably broadening to include certain features of social work in general, but it is notoriously difficult to generalise about the 'work' of social workers, in view of the varied settings in which they are located. The social workers that feature in this study, are drawn largely from mental hospitals, but even among them, the situation in which they worked differed considerably. In the subsequent fieldwork analysis, an attempt will be made to take account of this diversity, while drawing attention to the common features facing social workers working mainly in medical contexts.

Note on the origins of the child guidance clinics

Although none of the staff who were interviewed for this study were working in child guidance clinics, it is worth noting one or two points about their origins, as the development of both clinical psychology and psychiatric social work has been affected by them. According to Hearnshaw (1964) the first clinic to be opened for the "psychological treatment" of children was one established by the Jewish Health Organisation in 1927. He claims that the impetus for such a clinic had come from Burt (1925), who had advocated the establishing of

'psychological clinics'. However, Timms (1964a) has suggested that the idea for special clinics for children goes back to the British Child Study Association set up in 1893. While Dicks (1970) has pointed out that prior to the start of the child guidance clinics, children had been treated at the Tavistock Clinic. Indeed, the very first patient when the Clinic opened in 1920 was a child. In 1928 the Child Guidance Council was established and the first Child Guidance Clinic as such was opened the following year in Islington.

The Commonwealth Fund played an important part in the early development of this and subsequent clinics. Initially it financed the training in America of five social workers for the clinic, and as Timms (1964a) has pointed out, these social workers imparted something of their training on to other British social workers. The Fund also insisted that the demonstration clinic be used for training social workers and it also stressed the importance of affiliation with a university. The subsequent Mental Health Course, started at the London School of Economics in 1929 can be seen as providing the first course with the acknowledged aim of giving professional training in social work. As Timms (1964a) has rightly noted, this early association with a university had 'a considerable effect on the status and the development of training for psychiatric social work'.

The Fund was also influenced in other ways, for as Hearnshaw (1964) has observed, it insisted that Child Guidance Clinics be staffed by teams of psychiatrists, clinical psychologists and psychiatric social workers. In this way the two emerging lay professions were given a secure foothold in centres where the new 'psychological theories' were being applied. The security of their position was endorsed by the Underwood Committee that reported in 1956. The report recommended that a comprehensive child guidance service be available in every local education authority and that this be staffed by 140 psychiatrists, 280

psychologists and 420 psychiatric social workers. But as Timms (1964a) has recorded the actual increase of staffing has failed to meet these recommendations. In 1950 there were 51 psychiatrists, 162 psychologists and 93 psychiatric social workers, by 1960 there were 83 psychiatrists, 271 psychologists and 124 psychiatric social workers (p.92). Thus the psychiatric social workers have experienced the smallest increase in numbers, while the psychologists have had the largest, to remain the numerically dominant group.

Child Guidance Clinics have also been important centres of psychoanalytically orientated therapy that have developed outside of the traditional mental hospital milieu. Dicks suggests that it was precisely because of their independence from such hospitals and the doctors within them, that they were able to develop in the way they did.

Conclusions

The occupations of social work, clinical psychology and psychiatry, come together in a variety of different institutional settings. The mental hospital though, remains the most important one in terms of the number of patients treated, and the amount of contact between these occupations. For this reason the focus of this study is on the mental hospital situation, although some attention is given to a group of local authority social workers. At the present time there has been very

little work carried out on these occupations by sociologists in Britain. Thus in the accounts that have been given of the past development and present position of each of these occupations, information has been drawn from a variety of sources. The three accounts have not paralleled one another, as the questions that were asked have been somewhat different. However, the common theme was the 'professionalisation' of these occupations. All three of them can be considered to be emerging professions even though psychiatry has been established the longest.

In Chapter 2, it was suggested that professionalisation was essentially about the establishing of control over the application of knowledge. Once established, such control is rarely relinquished without a struggle. All three of these occupations have developed according to the professional pattern that emerged during the nineteenth century. Whether or not it is the appropriate pattern for dealing with madness, is a question that might well be asked. Whether there is a need for the many different occupational divisions within mental hospitals, let alone the three under consideration is a further question that is relevant to this study. While claiming to be only concerned with the 'interests of the patients', all three occupations justify their existence by subordinating the experiences and wishes of the patient, to their own definitions of what is in the patient's interests. The whole basis of being a 'professional' person stems from claims to have superior knowledge and experience over that of the 'unqualified' lay man. But it can be argued that an understanding of madness and the milder forms of mental disturbance and distress, may have little to do with the training given for these occupations. While these occupations may fight among themselves at times, they also uphold the belief that they, rather than outsiders, know more about the conditions they treat and the problems they resolve. At various points in these three accounts, reference has been made to the criticism levelled

against these occupations and to the emergence of groups within them, that express opposition to the present structure of these occupations. The possibility that alternative 'occupations' may arise to deal with madness should not be lost from sight, there are already various groups working on the fringe of psychiatry that have sought to cope with madness without having recourse to the existing professions.

The staff who were interviewed for this study were working under certain institutional constraints, thus this study itself reflects those constraints. It is primarily about staff working in mental hospitals, and thus the issues that it deals with may be particular to such hospitals. But it is also believed that such issues arise in other settings where an established occupation has to defend its dominance over others, who may be better equipped to deal with the problems to hand. In the past, studies on professionalisation have tended to concentrate on the associational developments within an occupation. In considering both social work and clinical psychology from the point of view of the organisation of these occupations, then they are becoming more 'professional' in the traditional form. But there is already evidence of a certain resistance to such developments among the members of these occupations, and a more illuminating approach would be to find out from the membership of these occupations, the meaning that professionalisation has for them. For it will be from within the membership that any new forms will develop and the processes of establishing the occupation will be experienced (1).

In the subsequent chapters, more attention is given to the situation

(1) In all three occupations the process of segmentalisation can be demonstrated. Further, the existence of various factions can further divide the members from one another. However, at the same time there are groupings and loose associations as well as training courses that draw their members from each of these occupations.

of the lay staff than that of the psychiatrists. This is because the problem of power and control in the situations being studied can best be examined from the perspective of the subordinate occupations. However, for the very reason that the psychiatrists are currently in a dominant position, their perspective on the situation is dealt with before that of the lay staffs. But before dealing with either of these questions, a brief description of the settings in which the interviewing was carried out is given in Chapter 5. Within this chapter material is also presented on the backgrounds and certain social attitudes of the subjects of this study. In Chapter 6, the different ideologies that were identified among the staff are described in some detail. As much of the subsequent analysis involves reference to these ideologies, they are described before dealing with the medical mandate that is dealt with in Chapter 7.

CHAPTER 5

THE SETTINGS AND SUBJECTS OF THE STUDY

Summary: This chapter provides a link between the earlier theoretical and historical background chapters, and the subsequent ones that deal with the empirical substance of this study. Certain information is provided on both the treatment settings in which the interviews took place, and more importantly on the people who were interviewed. Because of the diversity of organisational arrangement, between the eight settings, several general statements are made about the social structure of mental hospitals. Biographical details of the interviewees are presented, as well as certain social characteristics. The points of difference between the three occupations are noted, as providing indications of the position of these occupations, and their members, in the wider social structure of British society.

The settings of the study

The empirical substance of this study is based on 103 interviews carried out in 8 different settings. Six of these were large mental hospitals, one was a mental subnormality hospital and the other was a local authority mental health department. Table 1 below, illustrates the distribution of the staff between the settings. The names that have been given to these settings are of course fictional, and if there is a mental hospital with any one of these names, then the connection between it and this

study is merely that of having the same name.

Table 1: Distribution of staff between the settings

	Psychiatrists		Psychologists		Social Workers	
Woodlands	21	(55.3%)	6	(22.2%)	14	(36.8%)
Ashbury	10	(26.3%)	2	(7.4%)	8	(21.1%)
Oakdene	7	(18.4%)	4	(14.8%)	2	(5.3%)
Willows	-		5	(18.5%)	-	
Wheatbury	-		8	(29.6%)	-	
Cedar House	-		1	(3.7%)	-	
Beech Lodge	-		1	(3.7%)	-	
Local Authority	-		-		14	(36.8%)
TOTALS	38	(100%)	27	(100%)	38	(100%)

Woodlands, the setting in which the largest number of interviews was carried out can be characterised as being run on broadly 'therapeutic community' lines. By way of contrast Ashbury can be characterised as being more of a conventional mental hospital, although it had a therapeutic community unit within the grounds of the hospital. Interviews were only carried out in one of the sections within this hospital. The section concerned being the one that patients from the 'local authority' were referred to. At the time when the interviewing was carried out in the local authority mental health department, some of the social workers were attending ward rounds and other events at this hospital. In fact the interviews were carried out sooner in the local authority, than might otherwise have been the case, so that a group

of local authority social workers with 'specialist' experience of mental patients could be included in the study (1). The same local authority social workers also had contact with Oakdene Hospital when dealing with cases of subnormality. The choice of a subnormality hospital may seem somewhat surprising, but as was pointed out in Chapter 4, many psychologists believe they can make a more effective contribution in this area than in that of mental illness. The remaining hospitals were chosen because of the need to increase the number of psychologists.

Although Woodlands Hospital has been designated a 'therapeutic community' it would be a mistake to equate it with some of the small, intensive group therapy units that have been described in the literature on therapeutic communities (2). However, it did display some of the features of a typical therapeutic community, most notably the frequent staff and patient meetings. The former are particularly significant for this study as the rationale behind such meetings is the belief that they provide an opportunity for junior staff to participate, while enabling senior staff to communicate with juniors (3). It was noted in Chapter 4

(1) This meant that the interviews were not as detailed as subsequent ones - the problems this created for the analysis of the field work are noted in Notes on Methodology.

(2) There are many accounts of the therapeutic community, mostly written by official spokesmen for this position, such as Maxwell Jones (1953, 1956, 1968), Clark (1958, 1964), Clark and Myers (1970), Martin (1962), Freudenburg (1966). Jones and Rapoport (1957) have observed that the therapeutic community philosophy has four main elements, 'permissiveness', 'democracy', 'community' and 'reality confrontation'. Sociological accounts of therapeutic communities usually draw attention to the contradictions in these aims, and the lack of an effective technology with which to achieve them. See for example, Etzioni (1960), Perrow (1965) and Sharp (1973).

(3) The 'therapeutic community' unit at Oakdene was in many ways a more intensive one than that at Woodlands. The staff who were working on the ward in this unit that served the same catchment area as the local authority social workers, were also interviewed.

that several studies have observed the problems that junior doctors face on taking up appointments in such settings. While in Chapter 3, it was noted that in the Strauss et al study, social workers appeared to be espousing the 'sociotherapeutic' ideology. Although this study was never thought of as a comparative one, it was considered appropriate to carry out interviews in more than one setting, particularly as the findings of a study of one hospital, might be considered to be specific to that hospital. Mental hospitals more than most institutions tend to have their own histories, and past events continue to influence current practices. The uneven distribution of clinical psychologists between the settings being but one example of this. Where appropriate, reference will be made to particular points of difference between the hospitals, however, as this is a study of the way people represent their situation to be, rather than a description of their actions, such differences can legitimately be placed in the background. In Chapter 10, for example, there will be an account of the social structural position of the lay staff, which will include reference to their means of access to patients. This will involve noting some of the differences, however, for the time being it is more important to note certain general features of the way that staff relationships are structured in mental hospitals. Following Freidson (1970) who has observed that

> " ... the dominant profession stands in an entirely different structural relationship than does the subordinate profession" (p.137),

a brief description of the main features of the medical professions organisational dominance in mental hospitals will first be given, to be followed by a few observations on the general situation of the lay staff.

Various points have already been made in the previous chapters about the relationship between the three occupations under consideration. The

legal authority acquired by the medical profession over the last two hundred years was noted, as was the fact that the social workers now have greater control over the social services for the mentally handicapped. Such control though only applies to the provisions for patients/clients while they are outside of hospital. Once the patient enters the hospital, however, he becomes the 'doctor's patient' (1). The fact that he is the doctor's responsibility is re-affirmed in countless ways in the daily routines of hospital life. More importantly than this though are the procedures that are enacted that give strategic importance to the psychiatrists' decisions. Foremost among these are initial physical examinations and other tests of the patient's psychiatric 'state of mind', after which the doctor arrives at a diagnosis and prescribes the initial treatment, usually before any other member of staff has met the patient (that is with the exception of the nursing staff). Prior to these procedures, the decision to admit the patient will have been largely the consultant's, although social workers have certain statutory duties to perform over the admissions of some emergency cases. The statutory authority of the consultant and his power to place patients under detention orders, or on locked wards, give him certain responsibilities that are 'ultimately' his, even if he seeks to share the decision taking process with other staff. The extent to which psychiatrists involve themselves in the non medical aspects of their patients lives is largely up to them, the pervasiveness of their authority, however, is demonstrated by the way numerous non

(1) Goffman (1968), pp.305, has provided a detailed description of such stages.

medical decisions are continually referred to 'the doctor'. Once the patient is in the hospital, he may be seen, interviewed, or examined by a variety of staff quite apart from the doctor. In some hospitals, where, for example, social workers have offices attached to certain wards, they will encounter the patient as a matter of course, without having the patient referred to them. The same applies to some psychologists in some hospitals, though the practice is not as widely established as it is for social workers (1). Certain earlier studies, especially that of Rushings (1964) have identified 'gaining access' to patients as being a particular problem for some lay staff. This question is examined in some detail in Chapter 10, where it is taken beyond merely 'access' to examine the nature of the autonomy enjoyed by the lay staff.

Returning to the nature of the institutional dominance of the medical profession within mental hospitals; the fact that lay staff may not have to have patients referred to them, must be set against the rights of the consultants, and in their absence, the junior doctors, to decide on the relevance of the information provided by the lay staff for the diagnosis or treatment of the patient. In Chapter 7 the attitudes expressed by the psychiatrists towards the lay staff will be analysed, with a view to establishing how far, if at all, the psychiatrists rely upon and value the knowledge of the lay staff. As will be demonstrated in Chapter 7, many psychiatrists consider the act of arriving at

(1) At Wheatbury and the Willows Hospitals, the psychologists were attached to some units (at the discretion of the consultant) but at the other hospitals they generally worked from departments and usually only saw patients as a consequence of a referral. The social workers at Woodlands all had offices attached to admission wards, but at Ashbury they worked from a central department, although they were also attached to certain doctor's teams. At Oakdene the social workers only saw patients as a consequence of a referral from a doctor (or other member of staff). See Chapter 10.

a diagnosis to be their 'essential' contribution. The importance that such psychiatrists attach to physical examinations and neurological and other specialist services, have consequences on the sort of contribution that lay staff can make. A further, and a largely 'taken for granted' consequence of the medical profession's dominance is the general acceptance of the language of medicine. This problem was mentioned in Chapter 1, as affecting the perspective being taken in this thesis. Quite apart from the analysis by Goffman (1968) of this rhetoric, attention has also been drawn to it recently by Brown (1973) and Ingleby (1974). The medical model implicit in this rhetoric is continually re-affirmed through the use of the 'illness' metaphor as Sarbin (1967) has observed.

More important though than the pervasiveness of the medical rhetoric, is the strategic significance given to the medical profession because of their control over the use of drugs and physical treatments. The significance of this control can be appreciated through reference to certain institutional imperatives acting upon mental hospital staff (1). Foremost among these is the requirement that mental hospitals provide a service for a specified catchment area. Quite apart from the problems of providing beds to meet the demand from these areas, the consultants are faced with the task of reducing the number of beds within their hospitals, to confirm with the government's stated intention of running down the large mental hospitals. Consultants are thus expected to achieve

(1) For an analysis of 'institutional imperatives' in the context of a drama school see Hearn et al (1968).

a rapid turn over of patients on the admission wards. Quite apart from these imperatives, there has also been the problem of a general shortage of staff that has jeopardised not only the stated goal of therapy, but also the unstated one of custody, and containment. Thus quite apart from claimed therapeutic value of the physical treatments that are used, they have become functionally indispensible for the daily running of mental hospitals, because they either tranquillise otherwise 'unmanageable patients', or enable other patients to leave the hospital much sooner than would otherwise be the case. It has frequently been observed that psychiatrists themselves are divided over the therapeutic value of these treatments, and thoughout the subsequent chapters there will be repeated reference to the dilemmas that the lay staff find themselves in over the use of physical treatments. While some psychiatrists justify their dominance by referring to the need for them and them alone, to administer physical treatments, there are examples of units in which patients themselves have largely decided their own medication (1). Further, lay staff often claim that they are in a better position to understand the side effects of drugs. This question will be explored in Chapter 9, for the time being all that need be said is that the medical profession have a monopoly of certain technical skills essential to daily functioning of most mental hospitals, bearing in mind the institutional imperatives within these hospitals. Whether or not these skills are a sufficient basis upon which to claim to the <u>the</u> profession for the treatment of mental illness will be considered in Chapter 8.

(1) Schatzman and Bucher (1964).

A brief account of some of the features of the medical profession's current institutional control of the hospitalised treatment of mental illness has been given. It will be the task of subsequent chapters to elaborate upon these features in more detail. In particular, the consequences of this dominance for the lay staff will be examined. A few general points can however be made about the ancillary professions of clinical psychology and 'psychiatric' social work. In Chapter 4 attention was drawn to certain dilemmas facing both clinical psychology and social work in mental hospital settings. The lack of unity within both occupations and the inherent segmentalisation and fragmentation was noted. The particular problems of regarding social workers as a unity were noted; the varied backgrounds and levels of training of social workers were regarded as hampering the current attempts to professionalise social work. Further on in this chapter, certain background material on the staff interviewed for this study will be presented. This material corroborates these points. Leaving this aside for the moment, certain common features in the situation of both the psychologists and social workers can be commented on.

Assuming that members of both occupations require contact with patients to fulfil their own occupational mandates, then they are faced with the problem of gaining access to patients (1). Assuming that this presents no real problems, the question then becomes one of how far can such staff do what they like with the patients they see? For this must surely be one of the criteria by which to judge how far these occupations

(1) In the study by Rushings (1964) the major problem facing the social workers was gaining access to patients.

can professionalise, while in a subordinate position to that of the medical profession. The problem cannot be left there, however, for unless some account is given of what members of these occupations take to be their expertise, then the mere fact of autonomy to do what one likes, gives no indication by itself of whether or not their contribution can be regarded as a 'professional' one. The picture becomes complicated, by the evident disagreements within these occupations as to the nature of their expertise. Further, ancillary professions are often recognised for, and expected to fulfil, certain tasks that they no longer wish to be associated with. In Chapter 4, reference was made to the way many clinical psychologists are seeking to divest themselves of their 'testing' work. But most new lay, and also medical staff are not free to choose the terms on which they work, even if they are granted considerable leeway over how they organise their own work (1). Psychiatric hospitals may no longer be rigid, bureaucratic institutions but it is questionable how far they display all the features of the 'arena' model of organisation identified by Bucher and Stelling (1969) (2).

In the analysis of the interview material in the following chapters, the social workers and psychologists will be considered both separately and together. Where they are treated separately this will be because of the particular issues being considered. More attention will, however, be given to the common features in the general situation facing both groups. and the sub-groups within these occupations. In this way attention can be directed towards the way in which a dominant occupation seeks to

(1) The social workers being more constrained by the setting than perhaps either of the other two.

(2) See Chapter 10 for a discussion of this.

preserve its institutionalised control over the application of certain knowledge and skills. This can be done through an analysis of the way in which the lay staff define their own situation, quite apart from examining the way in which the dominant group seeks to defend its position.

The subjects of the study

Before considering the various themes that have been identified in the earlier chapters, it is necessary to provide certain background material that was collected on each of the interviewees. This material was gathered through the administration of a short, fixed choice questionnaire that was filled in by the subjects themselves. These were given to the subjects at the time of the interview and collected from them at a later date. A one hundred per cent response rate was thus achieved, though only after repeated requests were made to a few of the staff. These questionnaires were given out so as to collect certain biographical details from each of the subjects in the most economic fashion (1). Various references have already been made to the earlier studies that have noted differences between these occupations. The most comprehensive of these has been that of Henry et al (1971) in which they give a detailed breakdown of the social characteristics of psychiatrists, psychoanalysts, clinical psychologists and psychiatric social workers. This study was carried out in the United States, as was an earlier one by Hollingshead and Redlich. Both draw attention to the way that psychoanalysis in

(1) A copy of this questionnaire can be found in Appendix 2.

particular, provided a means of upward mobility for doctors from Jewish, immigrant families. Henry et al found that throughout all the occupations there was a large proportion of Jewish members and further that the majority were upwardly mobile. They also claim that all the occupations hold 'liberal' political values, though the psychiatrists were less liberal than the others, while they also found higher levels of agnosticism and atheism among their sample than among the population as a whole. Some of the background material that was collected will be introduced in subsequent chapters. The tables that are presented in this chapter bear immediately on some of the issues that have already been raised. They also give some insight into the social characteristics of the people who were interviewed for this study.

This information can be divided into two parts, firstly that which gives certain details of the age, sex, class background of the interviewees and secondly, that which provides information on certain attitudes and values of the interviewees, that can be considered of some relevance in helping to locate the occupations within the wider social structure of British society.

Biographical details

Starting with the most basic details, the social workers were largely female whereas the psychologists were more likely to be male than any of the other occupations.

Table 2: Sex of interviewees

	Male	Female
Psychiatrists (Ps)	60.5% (23)	39.5% (15)
Psychologists (Cp)	63.0% (17)	37.0% (10)
Social Workers (SW)	28.9% (11)	71.1% (27)

The importance of these differences has already been noted in Chapter 4, and clearly it is necessary to note the lateral roles that members of any occupation also have that influence their investment and commitment towards their occupation (1).

As well as there being differences between the groups in the sex of the interviewees, there were also differences in the age.

Table 3: Age of interviewees

	Less than 30	30-40	40-50	50+
Ps	26.3% (10)	39.5% (15)	18.4% (7)	15.8% (6)
SW	42.1% (16)	28.9% (11)	15.8% (6)	13.2% (5)
Cp	51.9% (14)	29.6% (8)	11.1% (3)	7.4% (2)

Thus both the social workers and psychologists were predominantly 'young', and as one might expect from this fact tended to be in junior positions in their occupations and also to have had fewer years experience of their work (2). The structure of opportunities within the three occupations

(1) See Olesen and Whitaker (1968, 1970).

(2) Although the 'youngest' group, the psychologists had the highest number of 'married and married with children' members, some 66.6% falling into this category, compared with 57.8% of psychiatrists and 39.5% of the social workers (provides evidence of the way women seeking a career have to 'foregoe' having a family).

differs, but even so a higher number of 'senior' psychiatrists were interviewed than either social workers or psychologists (Table 4).

Table 4: The occupational positions of the survey population

	No	%
Psychiatrists		
Consultants	13	34.2
Med. Assistants	2	5.3
Senior Registrar	5	13.5
Registrar	10	26.3
S.H.O.	7	18.4
Clinical Assistant	1	2.6
Total	38	100.0
Clinical Psychologists		
Principal/Consultant	4	14.8
Senior	8	29.6
Basic Grade	5	18.5
Probationer	8	29.6
Research	2	7.4
Total	27	100.0
Social Workers*		
Principal	2	5.3
Team Leader	2	5.3
Senior	2	5.3
Social Worker	16	42.1
Trainee	6	15.8
Assistant	5	13.2

Table 4: (cont)

	No	%
Social Workers*		
Unqualified	3	7.9
(P.S.W.)	2	5.3
Total	38	100.0

* These categories were ones that social workers gave themseves when filling in the questionnaire.

Significantly, many of the staff from all three occupations were in 'training' posts, though of course the extent of the training that they were receiving varied considerably. While many had gone on, were attending, or were hoping to attend various courses, a large part of the training experience of all three occupations followed the 'apprenticeship' pattern of learning 'on the job', under the supervision of a senior member of the occupation. As some of the lay staff had only been working in their occupations for relatively short periods, the attitudes that they expressed that are analysed further on, must be considered to be, in many ways transitional or temporary and as reflecting the 'situational learning' that is a feature of entry into new roles and social situations (1).

(1) As noted by Becker et al (1961).

Table 5: Years of work

	Less than 1	1-3	4-8	9-15	16-22	23-29	30-40
Ps	18.4% (7)	13.2% (5)	23.7% (9)	18.4% (7)	15.8% (6)	-	5.3% (2)
SW	15.8% (6)	31.6% (12)	28.9% (11)	13.2% (5)	5.3% (2)	-	-
Cp	18.5% (5)	25.9% (7)	33.9% (9)	14.8% (4)	7.4% (2)	-	-

In other words, 44.4% of the psychologists and 47.4% of the social workers had been working for less than four years in their occupations unlike the psychiatrists, of whom 31.6% had worked for less than four years.

At the time of the interviews, 34.2% of the psychiatrists possessed only their basic medical qualifications, 55.6% of the psychologists only had their first degrees in psychology, while among the social workers, 10.5% were without qualifications, 21.1% only had a basic diploma, while 18.4% had a first degree only (1). When asked where they had, or were currently undergoing training, the varied levels of training among the social workers in particular, become apparent. 36% (14) of the social workers replied 'none' to this question. However, among those social workers who did claim to have undergone some form of training only 7.9% referred to having undergone it 'in service'. In contrast, 48.1% of the psychologists and 50% of the psychiatrists had, or were undergoing 'in service' training. Significantly, there were relatively few staff from any of the groups who had been trained at either of the elite

(1) The differences between the three occupations over their 'qualifications' for various forms of therapy, and the extent to which members within them were pursuing higher qualifications, will be dealt with in detail in Chapter 8.

academic centres (1).

None of the occupations under consideration recruit school leavers, without their first having undergone some form of higher education. All psychiatrists have undergone a general medical training, and all psychologists have taken first degrees in psychology. In time all social workers will also have undergone comparable training courses of a degree or diploma level. As it is possible for members of all three groups to have had 'other work' experience, prior to choosing their current jobs, it is worthwhile noting the main differences between the three groups in this respect. As might be expected the social workers showed the greatest heterogeneity; 34.2% had previously been students, 7.9% had been doing other forms of social work, 26.3% various forms of non manual work, 13.2% psychiatric nursing before taking up mental health social work (2). In contrast, the psychologists showed greater uniformity, 48.1% having been students, 18.5% having been engaged in either research or teaching, while 11.1% had been working in other forms of psychology - either as educational or occupational psychologists. The relevant question to be asked of the psychiatrists, referred to previous specialisation in other areas of medicine. The largest group (39.5%) had not worked in anything other than psychiatry, 31.6% had worked in general medicine (3). Of the remainder, three had worked as GP's, one

(1) Four of the psychiatrists had trained at the Maudsley, as had three of the psychologists,while only one psychiatrist had trained at the Tavistock. Likewise, only one social worker had trained there, although three psychologists had done so. Five of the social workers had trained at the London School of Economics.

(2) NB: Ambiguity in question. 10 on sheet one of questionnaire.

(3) Some of these may have been counting their general medical work in their post qualification year as being relevant.

as a surgeon, two as physicians, two as neurologists and one as a schools' doctor. The importance of these factors has been shown by such studies as that by Kreitman (1959, 1962) where it has been shown how doctors with the greatest experience of general medicine have the greatest difficulty in adapting to working as psychiatrists.

Quite apart from such differences between these occupations in the area of their immediate previous work experience, there are other differences in their experiences of secondary education, that may have more bearing on the question of where the members of these occupations stand in the wider social structure of British society. It is widely known that medical students frequently come from public schools. The Todd Report (1968) having shown how they have increased their representation in medical schools in recent years. However, as the table below shows only 44.4% of those interviewed in this study had been at public schools (1). Even so, compared with the other two groups, more psychiatrists had been to public schools.

Table 6: Education

	Sec. Mod./Tech.	Grammar	Public	Other
Ps	5.3% (2)	44.7% (17)	44.7% (17)	5.3% (2)
Cp	3.7% (1)	59.3% (16)	33.3% (9)	3.7% (1)
SW	13.2% (5)	55.3% (21)	23.7% (9)	5.3% (2)

As might be expected, in line with this finding, the psychiatrists came

(1) The relatively low proportion may simply reflect the fact that only 55.3% of the psychiatrists were British, whereas 77.8% of the psychologists and 86.8% of the social workers were British. Thus in terms of nationality the psychiatrists were the most marginal, though as Table 7 shows they showed greater consistency in their class background.

from predominantly upper middle class backgrounds and also identified with the middle classes as the following tables show.

Table 7: Occupation of father (classified according to the Registrar General's categories)

	1	2	3	4	5	6	7
Ps	42.1% (16)	34.2% (13)	7.9% (3)	5.3% (2)	10.5% (4)	-	-
Cp	33.3% (9)	29.6% (8)	14.8% (4)	3.7% (1)	18.5% (5)	-	-
SW	10.5% (4)	26.3% (10)	18.4% (7)	13.2% (5)	13.2% (5)	7.9% (3)	2.6% (1)

Combining the first two columns the higher social class background of psychiatrists becomes readily apparent, 76.3% of them coming from 'middle class' backgrounds, whereas 53.0% of the psychologists and only 36.8% of the social workers had done likewise. The lower class origins of social workers has been noted in earlier studies (Heraud, 1972) and is likely to have consequences for social workers both at the interactional level and at the social structural level (1).

Social attitudes

The class differences between the occupations can also be seen in the following table that gives details of their class identity.

(1) The social workers as a group being the most upwardly mobile.

Table 8: Self assigned class position

	Upper Class	Upper/ Middle Class	Middle Class	Lower Middle Class	Upper Working Class	Working Class	Lower Working Class	None
Ps	-	39.5% (15)	52.6% (20)	-	2.6% (1)	-	-	2.6% (1)
Cp	3.7% (1)	25.9% (7)	63.0% (17)	3.7% (1)	-	-	3.7% (1)	-
SW	-	2.6% (1)	39.5% (15)	15.8% (6)	13.2% (5)	15.8% (6)	-	5.3% (2)

Whereas the psychiatrists and psychologists overwhelmingly see themselves as middle class, the social workers are much more mixed, with a significant proportion (almost 30%) seeing themselves as working class. The general identity with high status groups of the psychiatrists in particular, can be further illustrated by reference to replies to a question about views of society (1). The replies were categorised into what have been termed 'status' or 'power' models of society.

Table 9: Models of society

	Status	Power	Both	Neither	D/K
Ps	81.6% (31)	10.5% (4)	2.6% (1)	5.3% (2)	
Cp	48.1% (13)	33.3% (9)	7.4% (3)	-	11.1% (3)
SW	50.0% (19)	28.9% (11)	7.9% (3)	2.6% (1)	7.9% (3)

The differences that emerged over this question will be discussed in

(1) See Appendix for details of question 22.

Chapter 10, as it is believed they have some bearing on the attitudes towards collective action that were expressed by the interviewees. It is worth noting, however, that the group with the highest status and most power was the one that saw society mainly in status terms. This supports Prandy (1965) who has claimed that high status groups hold a view of society that is consonant with their own 'experience'.

Several of the earlier studies have suggested that psychiatrists can be differentiated among themselves according to the political values that they hold and the religious beliefs that they expressed (1). (Henry et al, 1971; Hollingshead and Redlich, 1958.) The 'liberal' person service professions might be expected to hold liberal political values as Parkin (1968) has demonstrated. However, the medical profession is generally characterised as being 'conservative' in outlook. As Table 11 below demonstrates, all three groups expressed a high degree of support for 'socialist principles', although when it came to actual party support, the social workers were more likely than either of the others to vote Labour (2).

(1) See appendix for details of questions 6-12.

(2) Table 10: Party support

	Conservative	Labour	Liberal	Abstain
Ps	26.3%	36.8%	2.6%	15.8%
Cp	11.1%	48.1%	14.8%	11.1%
SW	5.3%	55.3%	13.2%	21.1%

The beginnings of the alleged liberal revival might be found in these figures.

Table 11: Political principles

	Socialist	Conservative	Both	Neither
Ps	71.1% (27)	18.4% (7)	7.9% (3)	
Cp	92.6% (25)	-	3.7% (1)	
SW	78.9% (30)	-	2.6% (1)	10.5% (4)

A question was also asked about parents' political principles, the most significant finding being that across all three groups there had been a general swing away from parents' beliefs, with the exception of the social workers, among whom there was the highest proportion holding socialist principles. Similarly, many of the respondents had rejected parental religious values, or at least no longer belonged to the religious denominations of their parents. In contrast with the American studies, there were very few members of any of the occupations who were of Jewish origins (1). Social workers from Non conformist backgrounds appearing to be the ones to have remained the most faithful. Overall, 47.4% of the psychiatrists, 59.3% of the psychologists and 52.6% of the social workers did not belong to any religious denomination. At the same time, however, over a third of all three groups answered that they held some form of religious belief (2). Henry et al have made claims that all psychiatric professions are marginal because of their agnosticism, however, this claim may be particular for the United States, as the views expressed in this survey may be fairly typical of the cross section of society from which they come. Finally, the answers given to a question on how the respondents related their work to their leisure provide a further

(1) 11.1% of the psychiatrists, 5.3% of the psychologists, and 7.9% of the social workers. Half of all of these had themselves rejected any religious belief in Judaism.

(2) Table 12: Religious belief

	Reject	Indifferent	Believe with doubts	Believe with no doubts
Ps	28.9%	36.8%	21.1%	7.9%
Cp	22.2%	29.6%	37.0%	-
SW	18.4%	31.6%	21.1%	13.2%

illustration of the differences between the occupations. In particular, the social workers appeared to be the least 'committed' in the sense of seeking to dissociate themselves from their work in their leisure time. This may, of course, simply reflect the fact that a higher proportion of the social workers were women, however, as already noted there were fewer social workers married than psychologists.

Table 13: Work and leisure

	Overlap	Chance to be free	No relationship
Ps	47.4% (18)	28.9% (11)	23.7% (9)
Cp	51.9% (14)	18.5% (5)	22.2% (6)
SW	21.1% (8)	52.6% (20)	18.4% (7)

The question of how far social workers have lower levels of occupational commitment to that of the other two groups will be discussed in Chapter 10 (1).

Conclusions

The purpose of this chapter has been twofold, firstly to provide certain basic information against which to set the following chapters, and secondly, to make certain general statements about the current relationship between the three occupations under consideration. The

(1) See Parker (1972) for a study of the relationship of work to leisure.

tables that summarise the social characteristics of the three groups on the one hand support some of the points made about these occupations in Chapter 4, while on the other suggest questions that may have a bearing on the relationship between these three groups. For example, while the psychologists emerge as having had largely 'academic' careers, and showed much greater homogeneity of background, the social workers were the most heterogenous. Demonstrating the greatest variety of previous work experience, class and educational backgrounds. This might suggest that the social workers would be less united in the attitudes that they hold, not only towards their own occupation, but also towards the other two. The fact that very few of the population under consideration had been trained at the two elite centres with reputations for their ideological positions, might also be considered to have a bearing on some of the attitudes that are analysed in subsequent chapters.

The fact that a large proportion of all three groups were still in training, and in this sense not finally committed to their occupations, may also have a bearing on the perspective being taken by some of the subjects. Many studies on professional socialisation note the problems that neophytes have in their dealings with their own superiors, let alone the members of other occupations (1). It could be argued that a study on professionalisation should concentrate on the fully qualified members of the occupations being studied. However, it is believed that beginners and new entrants to situations, are often more aware of various problems facing the occupation, than their more established and senior colleagues.

(1) See Becker et al (1961), Olesen and Whitaker (1968), Bucher (1969), Heraud (1972).

A profession can only establish itself and survive so long as its new members follow in their senior' footsteps. This study is therefore concerned to examine the perspective being taken towards these processes by not only the established and committed members, but also the beginning and undecided members.

The Advanced Board

CHAPTER 6

THE IDEOLOGICAL TYPES

Summary: This chapter contains a preliminary description of the material that subsequent chapters will deal with in more detail. That is, within this chapter there are short descriptions of what are taken to be the main ideological types or categories to be discerned among the subjects of this study. There are seven different types to be described, the 'doctors' and 'eclectics' among the psychiatrists, the 'welfare workers', and 'therapists' among the social workers, the 'testers' and 'professionals' among the clinical psychologists, and finally the 'dissidents' who were drawn from all three occupations. Before outlining these ideological typologies, certain qualifications are made about them. A schema of the main elements and points of difference between them is also presented.

Introduction

In Chapter 3, there was a discussion of the different ways in which ideologies have been identified and measured in the mental health field. It was suggested that a much wider range of ideologies might be discovered among mental hospital personnel if a more socially grounded approach was taken. In Chapter 2, it has also been suggested that an important aspect of the social processes surrounding professionalisation has been the generation of ideologies that express the claims that occupations make for themselves. It was also pointed out in this chapter, that it is misleading to think of occupations as being necessarily united as to the nature of their tasks and role within society. In Chapter 4, this point

was documented by reference to the differences of opinion that have been expressed by spokesmen and the leaders of these professions, as to the direction that they should be progressing in. Further, it was also noted that the membership of these occupations may view the role and mission of their profession in a somewhat different light to that of their spokesmen, indeed some may even be opposed to attempts to become 'more professional'.

The ideological types to be described genuinly 'emerged' during the analysis of the interview material (1). As will become apparent, features of the ideologies might have been expected before the field work was carried out. However, the elements that have been gathered together into the different ideologies,have been selected and grouped according to the apparent importance attached to certain issues and beliefs by the respondents themselves. This means that the components of these ideologies do not exactly parallel one another, although as the schema below demonstrates, they can be contrasted along certain dimensions. This schema has been drawn up so as to highlight such differences, but the similarities and the waythese ideologies fade and shade into one another, should not be lost from sight. The categorisation of each of the interviewees into one ideological type was a difficult and somewhat arbitrary task. At one stage a series of 'in between' categories were developed such as 'therapist - welfare worker 'therapist - dissident', 'dissident - therapist' and so on, but these were abandoned, as the numbers involved are too small to sustain such fine distinctions. Though as a

(1) Reference has been made in Chapter 1 to the theoretical value of this approach. In Notes on Methodology in the Appendices the practical details of the procedure are discussed.

consequence of this merging of the earlier categories there has been an obliteration of the way in which there were some 'eclectics' for example, who expressed certain 'dissident' or 'doctor' attitudes. This was unavoidable in the presentation of these typologies, as the task of this chapter is to highlight the discernible differences within these occupations. Thereafter in subsequent chapters, such differences will often be 'suspended', even if they are referred to, as the focus will be more immediately on the inter-occupational contrasts.

The choice of terms with which to describe the different ideologies posed various problems. As far as possible the term that was chosen arose or emerged from the interviewees themselves, in so far as a certain term was used more frequently by some of the staff than others. None of the terms that have been chosen are meant to be denigrating, although values are attached to these terms and thus they will inevitably be interpreted as having certain connotations. A particular problem is posed by the choice of the terms 'doctor' and 'therapist' as these are words used frequently by all the staffin their interviews. Whenever the word 'doctor' is used in the quotations from the interviews with other staff, it should be taken to mean 'psychiatrist'. Likewise, it should be evident from the context, when the term 'therapist' is being used to describe one of the ideologies.

After each quotation a code number is given that identifies the interviewee. These numbers also provide a short hand guide to the occupation and setting of the interviewee. The first figures refer to the occupation, thus 1's are psychiatrists, 2's are clinical psychologists and 3's are social workers. The next figures refer to settings, thus Oakdene (the subnormality hospital) is 4, Woodlands (the 'therapeutic community hospital') is 5, Ashbury (the more conventional hospital) is 6,

and the two hospitals with psychology departments are 8 (the Willows) and 9 (Wheatbury), while the two remaining hospitals with single psychologists are both 7, so that the psychologist at Cedar House is coded 2700, and the one at Beech Lodge is 2701. The Local Authority social workers are coded 2. Thus 3507 would be a social worker at Woodlands, 1604, would be a psychiatrist at Ashbury and so on.(1)

In some respects this present chapter should be considered as a prelude. Within the descriptions of the ideological types, the various themes to be developed in subsequent chapters are introduced. This means that there will be some repitition of certain points. However, this seems unavoidable in view of the problem of on the one hand attempting to point to the complexity of the situation and the differences among the staff, while on the other hand, attempting to suggest where there are similarities, and to illustrate the way in which a 'working consensus' is maintained through the sharing of certain values. Further, the process of describing and analysing the current structure of relationships among the mental health professions, involves looking at certain issues from the differing perspectives of the three professions while within each of these professions there are different perspectives, or ideologies as they are being termed here. Thus the task is a complex one, and the ideological typologies that are being described in this chapter were developed as a partial solution to the problem of illustrating the contrasts, while at the same time bringing together certain common themes.

(1) An index of all the respondents' quotations will be found on pages 388-390.

SCHEMA OF MAIN ELEMENTS WITHIN THE IDEOLOGIES

	Welfare Workers Doctors Testers	Therapists Eclectics Professionals	Dissidents
Expertise/tasks	Exclusive/ limited	Inclusive/ broad ranging	Limited/ Denigrating
Division of Labour	Clear cut/over-lapped edges	Blurring/over-lap at centre	Should be complete overlap
View of other staff's role	Restrictive	Liberal	Liberal
View of Psychiatrists	Superior knowledge - leadership treatment	Limited knowledge coordination treat psycho-ses	Reject medical model but accept drugs
Mental illness as a medical problem	Almost entirely	Equivocal	No
Treatment	Drugs/physical practical care	Psychotherapy as real therapy use drugs	Live through and learn
Doctor's authority	Legitimate	Mixed	Illegiti-mate
Awareness of direction	Little if any	Some - not restrictive	Aware and resentful
Disagreement with other staff	Rarely if ever	sometimes	frequently
Own relevance	Yes, important	Yes, could/ should be more so	Very little
Attitudes to own profession (SW and Cp)	Mixed - anti professional-isation	pro - keen to professionalise	anti - critical of profession
Attitudes to training	Practical experience	Academic	Personal knowledge
Relations with patients	Distance/ neutrality	Mixed - be person but transference figure	Involvement
Collective action	Mixed - over social/polit. issues	Mixed	Keen - if ineffective

Table 14: The distribution of the ideologies

	Doctor	Tester	Welfare Worker	Eclectic	Profes-sionals	Thera-pist	Dissidents Ps	Cp	SW	Totals
Woodlands	7	0	4	12	4	7	2	2	3	(42)
Ashbury	5	1	4	5	1	2	0	0	2	(18)
Oakdene	5	0	2	2	4	0	0	0	0	(11)
Cedar House	-	1	-	-	0	-	-	0	-	(1)
Beech Lodge	-	1	-	-	0	-	-	0	-	(1)
Willows	-	0	-	0	3	-	-	2	-	(5)
Wheatbury	-	0	-	-	6	-	-	2	-	(8)
Local Authority	-	-	5	-	-	8	-	-	1	(14)
Totals	17 (44.7%)	3 (11.1%)	15 (39.5%)	19 (50%)	18 (66.7%)	17 (44.7%)	2 (5.3%)	6 (15.8%)	6 (15.8%)	(103%)
	35 (31.8%)				54 (53.4%)		14 (14.4%)			

It is evident from the above table that the psychologists were much more alike than either of the other two occupations. Indeed the 'testers' only differed from the professionals in matters of emphasis, and thus a much shorter outline of this ideology is given than of the others. The above table shows that the 'centre' ideologies of 'eclectics', 'professionals' and 'therapists' to be the largest group. The significance of these ideologies may go beyond their numerical superiority, as it is believed that an analysis of the components to be found within them may provide some account of the apparent consensus and conservatism that can be seen to characterise much of British psychiatry. As the schema of the main elements of these ideologies has shown, there are certain similarities between the ideologies among the different occupations. Such similarities being clearest among the 'dissidents' within each occupation. Consequently, the dissidents from each occupation are brought together in this chapter, but they are treated separately in subsequent ones.

The Doctors

The term 'doctor' has been used to describe one group of the psychiatrists simply because some of them used the term itself to draw attention to the importance that they attached to being thought of as 'doctors'. That is, such psychiatrists often talked of themselves as being primarily 'medical practitioners' or 'physicians' as opposed to psychiatrists. Three of them even questioned whether there was any need for there to be a separate specialty of psychiatry at all (1). One quotation selected from many similar ones illustrates this point.

> "Certainly mental illness should be a medical problem, very much more so than it is at present. Very many illnesses are essentially physical. To be a good psychiatrist one has to be a good physician. One of the problems of psychoanalysts is that they have had no medical training. One needs a higher degree in physical medicine for psychiatry - to be a good diagnostician as you cannot decide upon the therapy until you have diagnosed. Once the doctor has diagnosed then the other agencies can participate in certain kinds of ways. But in a clinical situation there is a clinical role for the doctor." (1407)

In many ways this quotation says almost everything that needs to be said about the doctors. There is above all else the assumption that the role of the doctor and his relationships with other staff should be just the same as in any general hospital, as 1506 asserted, "The situation is comparable in every way with that of general illness", or as 1517 put it, "the role of the doctor is as important in psychiatry as that of the surgeon is in surgery". The reason for this being that, "many of the conditions that many people come into hospital with are illnesses in the sense that cancer is an illness, and these can only be properly dealt with by a doctor" (1508), or as 1605 observed "The treatment of most mental illnesses

(1) In this context, many doctors expressed their opposition to the formation of a Royal College of Psychiatry.

will increasingly be like that for diabetes, even though the patients will require special handling for their emotional problems". In other words, a central component of the doctor ideology is the belief that psychiatry is primarily a medical specialty because in their terms, the problems that they are dealing with are illnesses. Applying therefore a medical model to the condition in front of them, they assume that they must necessarily play a central part in deciding what happens to the patient.

This can be illustrated from the following quotation from one of the consultants

> "The most important thing of all is to get the diagnosis right, otherwise everyone is wasting their time. Only the doctors can make the diagnosis, and then they decide upon the treatment. No one else can make this decision, this covers all sorts of treatment from physical treatments, psychotherapy and psychoanalysis. Beyond that, the main thing is to give the team some sort of direction towards what you think is right" (1601).

The question of direction will be returned to shortly, for the moment it is important to draw attention to the way the doctors more than the other psychiatrists stressed their own importance in deciding upon the treatment, not only by drawing an analogy with physical illness, but by suggesting that only they have had a training that equipped them to understand mental illness. Not all the doctors would have extended their role to include deciding upon the relevance of psychotherapy and psychoanalysis, for another feature of their view of themselves was their tendency to restrict themselves to physical treatments, even if some of them did not disavow carrying out psychotherapy. Many doctors openly stated a preference for treating psychotic patients, 1509, for example, commented that "I have little sympathy for, or ability to get along with neurotic patients. I much prefer treating psychotic patients, at least we can do something positive for them." (1) In other ways, there were several indications

(1) She elsewhere stressed how "the treatment for the psychoses must be left to the doctors as it is primarily pharmocological, whereas I don't think it matters who treats the neurotics".

that many of the doctors found working in psychiatry to be frustrating, because of the uncertainty that surrounded much of their work. One such doctor compared her present work unfavourably with her previous job as a schools' doctor, "Where at least I knew what I and everyone else was doing" (1521).

While there were some doctors who gave long lists of the various activities that they were involved in, these often tended to be of an administrative nature, when not specifically concerned with the patient's treatment. Overall the doctors were much more likely than the eclectics to take an exclusive view of their expertise by stressing their medical skills. For example,

> "I see it as dealing with the primarily medical aspects of things. As a psychiatrist, one is first and foremost a doctor and so one is dealing with the medical aspects of the situation. I disagree with those colleagues who think they have a divine right to take part in all aspects of the patient's care. There are other staff who are more capable than us at some things, and we should let them get on with it" (1506).

In this way there are some parallels between themselves and the welfare workers and testers. The important point about the doctors' claimed expertise, being their stress upon diagnosis and treatment as the exclusive prerogatives of the medical profession. From this belief there follows the assumption that the medical profession will direct the team, as one doctor expressed it

> "Medical direction is very important, after all we are dealing with an illness. Most patients need and require physical treatments and these must be in the hands of the doctors. We are also after all responsible for what happens. It is only natural that the leadership should be in the hands of the doctors" (1603).

In contrast to the 'eclectic' psychiatrists, the doctors appeared less concerned about the 'problem' of leadership and instead took it for granted that they should have certain directive powers to 'dictate the treatment' (1405), or 'decide when social work is necessary' (1515) or 'arrange for the admission and discharge of patients' (1517). This raises the important question of the doctors attitudes towards and evaluation of the social

workers and psychologists.

The doctors differed from the eclectics in being much more specific about what they expected from both these lay groups. Indeed it was almost a question of not expecting anything from the psychologists, for only a few of the doctors expressed any appreciation for the work they did. In particular at Oakdene (the subnormality hospital) two of the doctors were notably scathing about the psychologists. One of them talked of

> "In general the majority of psychologists don't do anything useful ... I really cannot understand what their function is at all, they are a waste of the taxpayers money and it seems to me that it is only a matter of time before their fraud is discovered. I think that the money that is spent on the psychologists should go to the social workers instead" (1405).

The greater appreciation of social work will be commented upon after looking more closely at other doctors' views of the psychologists. In contrast with the eclectics who tended to suggest that the psychologists could do more than just 'testing', the doctors appeared to restrict them to this activity and then to regard it as being a very peripheral one. Typical of many was one who said

> "We don't use psychologists very much here, we don't feel any great necessity to do so. Our approach is more multidimensional. Here we don't bother with the categories that they use as they are not terribly relevant and they don't help you with the problems that we have in the here and now. We only use them for various forms of assessment, but we are doubtful of the validity of the tests they use" (1601)

In this way the contribution of the psychologist is not only made an auxilliary one, but it is denied any value at all, as it is only assessed in terms of its utility for the doctors concerned.

In contrast, the doctors expressed much greater regard for the social workers, nearly all of them stressed how important they were. For the doctors, the importance of social work typically lay in

> "helping the patients to adapt to the society that they live in. Taking social histories, finding accommodation, supporting the relatives and making sure that all the statutory agencies are being used in the right way" (1508).

In other words, the social workers were being valued for their welfare work but for little else, for as 1515 expressed it "The social workers would do better to forget about the illness and the treatment and instead they should concentrate upon the social problems". Several others expressed similar views, 1603 commenting that, "I don't see why they want to be in on the treatment as there is an awful lot for them to do anyway by just doing their own job". Thus the doctors, like the welfare ladies and testers, perceive what they consider should be a clear cut division of labour between what they do and what the other staff do. For them, confusion or overlap reflect a failure of team work, or rather of leadership, as 1602 expressed it

> "There has to be direction and the doctor has to provide the leadership. This is one of the failings of the therapeutic community, especially the one that we have here. Decisions get slowed down to such a degree, because everyone has to know about everything, that the thing becomes unworkable".

It is important to note that most doctors also expressed a wish to see other staff involved, but only on certain terms. They particularly welcomed the social workers, because they, like nearly all psychiatrists, recognise the importance of 'social factors' when dealing with mental illness. However, this does not alter the fact that most doctors believed the primary causes of mental illness to be of physical, biochemical or genetic factors. Some made the following sort of assertions, "50% are due to metabolic disorders, 50% are due to early childhood deprivations leading to neurotic and personality disorders - that is of the patients that we get here" (1601), or 1515, "It's only a matter of time before some clever biochemist will come up with the answer" (1). Most merely stressed organic factors,

(1) Other doctors expressed pessimism over the likely chances of schizophrenics ever being 'cured'.

without wishing to exclude social or psychological factors. Similarly, with regard to treatment, the doctors differed from the eclectics in so far as they stressed the importance of physical treatments much more, and were also more critical of non medical therapies, such as psychotherapy and the 'therapeutic community approach'. Overall, however, they stressed how pragmatic they were, and how they were "prepared to use anything that works" (1602), although 1406 noted that if she "could only use one thing, then I would insist upon them having drugs - plenty of them and over a long time". Like the eclectics, many of the doctors also denied identifying with any particular approach towards treatment, although three did mention the 'organic'. Others dissociated themselves from the extreme organic in the same way as they did from the extreme analysts, as one of them put it, "Be flexible in all things is my motto" (1600). The doctors were more opposed to certain approaches than the eclectics and several mentioned their dislike of 'anti-psychiatry', the use of 'psychoanalysis with psychotic patients' (1508) or the "unselective use of the therapeutic community" (1603).

At the outset of this description of the doctor mode of response, it was noted how the most important feature of it, was the way that such doctors tended to think of themselves as being like any other medical practitioner. The attitudes that have just been outlined provide support for the way such psychiatrists seek to see other lay staff as auxilliaries in the way that they are in physical medicine. In other ways as well, the doctors expressed their affinity with the world of general medicine. Most doctors, for example, stressed how important it was not to get 'too involved' with patients and how "the approach in psychiatry is the same as, or rather is inherent in the medical approach generally, to adopt a non moralistic approach, a detached and non involved approach as far as possible" (1506). This approach contrasts sharply with that being advocated by the

dissidents, and even by the eclectics who frequently mentioned the need to 'reveal something of yourself with patients', and to 'be oneself with patients' or 'involve oneself with patients'. One doctor in particular warned against such involvement, by saying

> "The distance that you keep from a patient is a very fine line and a very difficult thing. You must not get over involved with the patients. You must be cool and keep a barrier between yourself and the patient. You can go so far but no further otherwise they will be ringing you up at home and ruining your life as well as their own. Patients are like leeches, if they catch onto some weakness they instinctively know this. You have to be warm but firm, and it takes a lot of practical experience to cope with it. Social workers get over involved with patients in a terrible way" (1603) (1).

As an extension of the above issue there were doctors who also stressed how important it was to have a 'stable personality' and not to have 'problems of ones own'. There was a certain anti-intellectualism running through many of the interviews with all types of psychiatrists, but this was particularly apparent among the doctors. Many stressed the importance of 'common sense' and a 'practical' approach as being very important, while several thought that the attributes of a good psychiatrist could only be acquired after considerable experience with mental patients.

The Eclectics

The term 'eclectic' is being used to describe those psychiatrists who not only claimed to be eclectic in their approach to treatment, but who

(1) Another doctor accused the psychologists of "getting involved with the patients in an intellectually dilitante way, when the patients react they are unable to cope. The most significant aspect of your training is learning to combine ongoing sympathetic involvement with the patient while maintaining control over the situation" (1404).

also displayed a series of beliefs and attitudes that reflect an 'eclectic' philosophy. In general terms, this philosophy contained certain liberal and voluntaristic beliefs about the relationships of the staff to one another, the nature of the leadership role of the medical profession, and the extent to which the lay staff could participate in the treatment, and in the running of the hospitals. In other words, the term eclectic is being used to describe much more than merely attitudes towards treatment, for it is believed that this term, more appropriately than any other, conveys the impression created by those psychiatrists who believed themselves to be "all things to all men" (2502). In some respects the eclectics are the creators and creatures of the therapeutic community approach to treatment. Certainly most of them supported this approach, whereas many 'doctors' could be noted for their opposition towards it. It may be that the large number of eclectics within Woodlands Hospital was merely a reflection of the way these psychiatrists had come under the influence of this approach. (1). However, it is believed that being 'eclectic' means more than merely supporting the therapeutic community idea, as will become apparent in this outline of their ideology.

Unlike the doctors who located as their expertise, their medical knowledge and training, the eclectics were seeking a broader basis to their contribution. Most of them mentioned their 'routine doctoring functions' or "veterinary work" (1519) as one of them put it, as being a time consuming and not particularly valuable part of their work. As with the 'professional' psychologists and the 'therapist' social workers, there was a tendency to divest themselves, or dissociate themselves from the more

(1) As Table 14 on page 146 demonstrated.

routine and predictable aspects of their work. Some thought that ordinary GP's could do much of the work, especially that upon the long stay and geriatric wards. Others more specifically dissociated themselves from the way they had to routinely treat all their patients with drugs

> "Here the psychiatrists essential task is to treat all the patients as quickly as possible and send them back to the community - usually this is done with drugs and organic therapies and ECT. I do not use physical treatments from choice, this is not my approach, but I have to accept it" (1517).

While accepting their general medical role and the administrative duties that flow from it, most eclectics did not wish to restrict themselves to these activities, but instead to take a much broader and more inclusive view of their role. Thus there were references to not only being a therapist with the patients, but also with the other staff, to being a 'member of the community', to offering 'guidance' and 'support' for the other staff as well as 'liaising' between them and acting as 'coordinator' of the team, if not the 'leader' of it. There were references also to being the 'culture carrier', and being responsible for ensuring 'that everyone is contributing to the best of their abilities' and that there are no 'blockages to communication' among the staff. What emerges from these points is the concern of the eclectics to be acting as 'consultants' for the other staff in offering 'guidance' and 'leadership'. This concern was also expressed by some 'doctors', but they never attached the same importance to it as most of the eclectics. For example, one of the consultants, having noted how the consultant should have the "greatest technical know how about psychiatry", and should be "providing guidance and teaching for the other staff", observed that

> "In a psychiatric hospital such as this, he is much more than that. As the leader he will be responsible for any changes that take place in the situation, and thus will provide a social as well as a medical lead. Further, I consider that it is the task of the consultant to make the best of whatever is the best in each member. In a hierarchical structure as exists in this hospital it is up to the consultant to

> mobilise resources ... there is need for leadership and the doctor is the natural person to provide it. No one else can be as comprehensive as the doctor can be. I do not think that that can be the only possibly pattern, it may not be the best one, but it is the one that has emerged here" (1502).

Where the eclectics differed from the doctors was the way they invested 'leadership' with a special meaning, that meant that they personally were much more involved in the day to day decision taking upon their units or wards. However, in their own terms, this involvement was to ensure that "other staff participate and share the decision taking process. We must ensure that meetings don't become doctor dominated" (1501).

Clearly, as the above quotations show, the eclectics are not suggesting that they abandon the claimed superiority of the medical profession. As one of the other eclectics pointed out

> "In a therapeutic community set up like we have here, the roles are not clearly defined, this in itself does not matter, as an inter-disciplinary approach is where the borders of ones knowledge and training merge with that of the others. So while the others expect the doctor to be more knowledgeable about the psychiatric state and psychodynamic conflicts that the patient has, everyone has insights into the patient and the community. In the end, though, because of the responsibility of the doctor, and the doctor has the final responsibility, for the care of the patient, the other staff expect him to make a more important contribution" (1510).

What the eclectics are claiming is that other staff can also participate in the therapy and in the running of the community as these are not exclusively medical activities, but at the same time, they in no sense relinquish their medical authority. This quotation reveals a further dimension of the eclectic ideology. That is that 'other staff' are often attributed with not only 'expecting the doctors to make a more important contribution, but also with providing 'leadership'. Some were almost apologetic about this,

> "When I first came here I had hoped that I would be merely a member of the team, but other people look to the consultant to show the direction of working. Once in a meeting, everyone looks to the consultant for a decision" (1505).

Thus, although some eclectics justified their leadership role in traditional terms, the majority talked instead of 'coordination' or

'liaison', 'tying up what others are doing', 'offering guidance' or in some other way attempting to convey the impression of not being autocratic, while also suggesting that it was the other staff who expected them to act as leaders. Although not all the eclectics claimed to have superior knowledge of psychodynamics, as 1510 does above, most of them indicated how carrying out psychotherapy was one of their main interests. Four of them noted their intention to undergo further training and analysis so as to qualify as psychotherapists (1). Many of the eclectics, however, did not appear to attach particular meaning to the term psychotherapy, and instead talked in generalities about being a 'therapist'.

As noted at the outset, one of the distinguishing features of the eclectics was the belief that other staff should be involved in the treatment and care of the patient. This stemmed partly from the general belief that mental illness was more than solely a medical problem, as 1503 put it,

> "It's a problem that has its medical aspects, also a nursing problem, a social problem and above all a cultural problem. Mental illness is not a unity, nor are the people who deal with it".

Interestingly, all of the eclectics provided justifications for continuing seeing it as medical problem, even when they expressed criticisms of the limitations of the medical model (2). One thought that it should continue to be a medical problem as "this reduces the stigma, if it becomes a social problem it could revert to being badness again", he then went on to say that, "psychiatry should branch away from medicine and be more open to other influences such as sociology and anthropology" (1505). In this and

(1) This question is explored in more detail in Chapter 9.
(2) This issue is explored in some detail in the next chapter.

similar ways, the eclectics differed from the doctors in dissociating themselves from main stream medicine, whereas the latter were seeking to maintain an identification with medicine. Similarly, most eclectics were less assertive than the doctors, about psychiatry being essential for the treatment of mental illness. While all agreed it was necessary, many were equivocal in the sense of noting the limitations of their present methods and therapies. As one of them said

> "We haven't got anything much better. Drugs and physical treatments are extremely relevant but there are areas in which they are not effective, and then the only alternative is some form of psychotherapy" (1507).

As might be expected, the eclectics were more open and more accepting of other staff playing a more active role with the patients. Whereas some doctors believed that the lay staff should only engage in certain activities which only they could perform, most of the eclectics did not wish to appear restrictive. Indeed, a general feature of the eclectic ideology was the belief that within the therapeutic community in particular, that lay staff "as members of the community can take part with whatever gifts, or potentialities that they possess" (1501). A good example of this voluntarism was given by one of the other consultants in the same hospital

> "I would not like to differentiate the role (of social worker) too much. It often doesn't matter who interviews the patient or family, whether nurse, social worker or doctor. Similarly, with follow up, it is usually decided at the discharge meeting that the patient be followed up by whoever is best able to do it. ... There is no necessary reason why the doctor should not carry out social work, or the social worker carry out psychotherapy, but in general each person is better at something else. The sort of division that grows up here springs from the kind of treatment experience that the members have" (1502).

What is significant about this view is the suggestion that 'division of labour' that occurs between the staff, emerges out of their 'treatment experience' and the particular problem being considered, as if there was never any dispute over the necessary 'experience', or that some staff have

the authority to decide who has this experience. This consultant was quite emphatic elsewhere about the 'leadership' role of the consultant, and his own actions suggested he would stop junior staff treating patients if he disapproved of their approach (1). However, it is not the purpose of this study to adjudicate between the accuracy of certain claims, but rather to demonstrate the ways these claims reflect the images that various staff held of themselves.

More specifically, the eclectics tended to be more aware than the doctors that staff such as social workers and psychologists believed they could do more than merely welfare work or testing respectively. Somewhat paradoxically, however, this greater recognition did not mean that they were valued more by the eclectics than the doctors. For some eclectics who recognised that social workers might also be therapists as well as welfare workers, did not attach the same value to the latter activity as the doctors did. As one eclectic pointed out, after noting that both himself and the social worker carried out psychotherapy and saw relatives,

> "I suppose she arranges accommodation and social security benefits, which I see is her equivalent to my prescribing drugs. Certainly these should not be her central tasks and she has recently complained of having to do too much bread and butter social work. We are trying to do something about this" (1607).

When talking about the psychologists this same eclectic commented that

> "Ideally my relationship with a psychologist would be the same as with the social worker, the only difference being that he would do more complex tests and I would prescribe drugs. Not that a psychologist would see all the patients, there would have to be some selection - it all depends on the patients needs. Though in the area of inter-personal relationships there would be no need for selection".

This quotation again illustrates the 'liberal' basis of the eclectic ideology, for it suggests that an open structure exists in which different

(1) See pp313 - 4 for details of incident with a junior psychologist.

staff will meet 'patient needs' without control from other staff, or without there being contradictory definitions of patient needs (1). Further, because there is also a general belief that "In the actual treatment situation, the role is interchangeable, anyone on the staff could support a patient or give supportive psychotherapy" (1608), the claims made by some therapist social workers or professional psychologists to be skilled in these areas are devalued by suggesting that everyone has these 'therapeutic gifts' (1601). Thus, while the eclectics are more accepting than the doctors that the lay staff contribute in various ways, they rarely granted them recognition for having any unique expertise in anything but their most routine tasks. At the same time they were more likely than the doctors to talk of having a complementary relationship with the lay staff.

In various other ways as well there were differences between the doctors and the eclectics. As the term itself implies, the eclectics were likely to claim to be 'eclectic' in their approach to treatment. Some of them identified with certain approaches but usually only in generalities, such as 'the psychodynamic' or the 'therapeutic community'. Most stressed the importance of being 'open minded', and of "throwing out into the dustbin, whatever you don't find to be of use to the treatment" (1512). Another talked of

> "taking an eclectic approach, sometimes I use mechanistic explanations, at other times organic, or dynamic, or hereditary or sociological, without feeling any incongruity. I myself have carried out almost all kinds of therapies from leucotomies to depth psychoanalysis" (1502).

However, although the eclectics claimed more often to be "eclectic" than

(1) A consultant at Woodlands suggested that "I haven't a clue what the role of the psychologist is, it depends on what they choose to make it. Here it centres around research, testing and certain amount of therapy ... I wouldn't presume to say what it should be" (1503).

the doctors did, it must be noted that a general feature of the psychiatrists, was their disavowal of 'ideological extremes'. As might be expected the eclectics were less inclined than the doctors to stress the pre-eminance of organic factors causing mental illness, although many noted how they could not be ignored. Instead, there were more frequent mentions of the importance of 'social factors', such as bad housing, and of the role of 'current interpersonal interaction'. Returning to the question of their view of their own expertise, it was the sheer variety of possible factors that provided the basis for many eclectics claiming that only they, the psychiatrists, could fully comprehend and integrate all the various factors, as one of them claimed, "Psychiatry is essential as it encompasses all the other fields and disciplines, religions, community work, sensitivity therapy, group work, as well as the natural and social sciences, genetics and biochemistry, etc" (1607).

The Welfare Workers

As the term implies the welfare workers saw their essential tasks to be those that might be loosely termed 'welfare' activities. These included

> "looking after the social environment, housing, pensions, rent and contacting relatives. I am working mainly with old people, so such things as pensions are important. Obviously, not the medical problems, more the social" (3604).

Others referred to how they "gathered information for the doctors, upon the patient's relatives" (3401) or how "I try to find out from relatives what was happening that led to the breakdown" (3502). There were also references to how they liaised with 'community agencies' and arranged "accommodation for patients going to be discharged" (3501). Others

commented on how "seeing relatives, so as to get them to understand what we are doing to the patient" (2508) was the most important part of their work. What was striking about most of the replies from the welfare workers was their evident satisfaction with the work they did, as one of them expressed it "There are so many practical things that you can do for an elderly person that help a lot. You can give them all the care that they want" (1). Not that some references were not made to 'therapy' as being one of their tasks, but rather it was not given primary importance. Though there were a few who specifically stated that "I am not a therapist, I would not attempt it. Instead I talk to patients on their level as someone they can trust and who can provide practical assistance" (3205) (2). Although taking group therapy, one such social worker commented that

> "I use my group for the giving and getting of information, for assurances and personal interest. I am very wary of using it for any form of therapy ... I try to contain any activity that is going on within it" (3509).

As many of the above comments imply there is a tendency to see oneself as an extension of the psychiatrists, which for some meant that they saw themselves as complementing the psychiatrist, such as "the psychiatrists treat the illness whereas I deal with the social problems arising from the illness" (3600), or as being auxilliary to them

> "My kind of social work is to reinforce and back up the psychiatrist considers applicable to a particular type of patient" (3211).

(1) Further on attention will be drawn to the way some of the dissident social workers also thought they should restrict themselves to such activities.

(2) There was evidently a certain amount of acrimony among the social workers in the L/A "I know my limitations, I don't agree at all with those social workers who think they are GP's of psychiatry and can take over as the therapists. We are not psychiatrists though some PSW's may like to think they are" (3211).

Overall, such social workers believe their activities to be valued by the psychiatrists that they work with. Most indeed commented upon the good working relationship that they had with certain doctors. This will be returned to further on, suffice it to quote one of the principal social workers as saying

> "I work very well with Dr A, we understand one another. He refers cases to me, but if I don't think that social work is appropriate, I will tell him so and he will accept this. I always accept his medical diagnosis and he accepts my social diagnosis. If he thinks they are too ill to require social work help, then I accept this" (3600)

Several related issues are raised by these comments, that demonstrate further facets of the welfare worker's view of themselves and their relationship with the doctors. Most of them thought that there was hardly any overlap in what they did, as 3400 noted "We all know our roles". This meant that most of them considered the psychiatrists' essential tasks to be

> "diagnosis, treatment, deciding upon admissions, using all the various ancillaries. In the treatment of psychiatric illness he is the king pin. His essential role is to diagnose and delegate treatment in the appropriate way" (3206).

Most such social workers tended to see the diagnosis as something that was decided by, and the affair of, the doctor's, even if they also thought that "we can aide the diagnosis by providing as much information for the doctor as possible" (3508) (1). Similarly, most appeared to see treatment as being the prerogative of the psychiatrists. But whereas the 'therapist' social workers tended to limit the doctors to physical treatments, the

(1) As 3600 expressed it "I am not interested in the diagnosis, it's immaterial to me". Although another was more clearly aware of the consequences of the diagnosis upon his own work "... to be diagnosticians, this will determine the treatment and largely govern our own contribution" (3210).

welfare workers saw the psychiatrists as having much wider abilities and talked of how

> "they carry out the treatment, and have a complete understanding of the patient and the situation that they live in, their social surroundings and everything affecting the patient" (3205).

Others made references to how they expected them to provide the 'leadership'. For some this was because they were 'responsible', but there were also suggestions, as from 3508 that this was "because we cannot do without a psychiatrist because of his greater understanding and training". One social worker commented that psychiatry "was 100% essential" (3600), and while not all the welfare workers were so emphatic, most of them stressed its importance. Some expressed the view that physical treatments now provided cures, or if not, were essential palliatives. Further, most such social workers saw mental illness to be a medical problem, even if some qualifications were expressed. One, who expressed no qualifications, commented that "Yes, very much so, definitely a medical problem, in the sense that if you go down to the doctor, you expect him to treat you" (3401). Another thought that

> "it is an illness and it ought to be curable, and it ought to be preventable as other illnesses are. The trouble is that relatives won't accept this - they will not see a parallel between paranoia and flu" (3604).

The consequences of these attitudes is that most such welfare workers accommodate themselves very well to the approach being taken by the psychiatrist. While not being deferential, most of them expressed the view that it was right that the doctors should have directive powers "In a hospital you accept this direction" (3508) was a comment echoed by several such social workers. One commented upon the way there was "an order in things" (3210), while another noted "That I think it's important that there is someone in authority that you can look to, but the doctor should be more of a colleague than a boss" (3604). In such ways most of the welfare workers

accepted as legitimate the present structure of relationships. Few expressed any dissatisfaction with the differences in status or financial rewards between the various staff (1) (2). One even commented that

> "they are in a higher strata to social workers. I have never thought that I ought to have the same status as a doctor - I certainly don't - haven't all psychiatrists done a medical course?" (3205).

Others noted the psychiatrists' longer training and responsibility as justifying their higher salaries and status. Significantly, the approval that most welfare workers expressed for medical therapies, the clarity with which they perceive the division of labour, and their overall accord with the values of the other staff, meant that most of them felt there was very little, if any direction over them. As 3604 claimed "I can do what I like, when I like, how I like". Another felt that "we are directed in the sense that we are requested to do certain things, but there is no actual supervision over how we do it" (3510). None expressed any resentment against such 'direction'. As regards their view of mental illness and how it should be treated, most welfare ladies gave much more 'medical' views than either the therapists or dissidents. Some indeed saw a primacy in the bio-chemical and organic factors and especially in 'hereditary' (3508 and 3205), though many also mentioned environmental factors, early childhood experiences and so forth. What is more significant about the welfare workers was either their disavowal of identifying with 'particular approaches to treatment' or their expression of ignorance about them. Those who

(1) Significantly, several of the women related their satisfaction with their low pay to the fact that they were not the 'breadwinner'. Though there was some dissatisfaction noted over the differences between hospital and local authority social workers, and within branches of local authority social work.

(2) 3600 said "I do not think there is any difference in status" while 3200 was primarily against the way "the PSW's set themselves above other social workers".

identified with anything considered themselves to be 'eclectic' (3600) or 'I use the best of everything' (3201). Similarly, they nearly all denied any hostility towards particular approaches. The exception being the LA welfare / social worker's social workers who nearly all expressed their hostility with the way some "social workers think they are analysts" (3210) (1). Such tolerance of all approaches may have been based upon ignorance of them (as 3501 claimed) but it may also have been related to the way most of the welfare workers stressed the role of practical experience over academic learning. Again some bitterness was expressed against the moves to require all social workers to undertake further training. As 3205 said

> "The most important thing is working with people in the field, it's the only way you will know whether you will make a personal success of social work. For myself I feel confident about doing the job without specialised training, I have had mine from my experience of life".

3213 expressed similar sentiments more graphically when he talked about "common sense that's the most important thing - it's difficult to define - intuition, going by ones nose, smell them out, going by ones intuition without knowing why". Or as 3210 put it

> "Practical experience is what makes a good social worker. It should be 98% practical experience in the community and in mental hospitals. I feel very hostile towards qualifications, at least to the way it has been done - the people on professional courses have plastic minds straight out of plastic moulds".

Clearly, almost by definition such social workers are the ones who are considered to be untrained by BASW, and as might be expected they were either completely against the reorganisation of social work, or very ambivalent about it, or as one of them expressed it "I have chosen to remain ignorant about it" (3509) (that is the idea of having a register of social

(1) 3205 commented how "I am very anti-analysis, especially for social workers, I consider that it makes the people ill who go in for it - I see no value in it as an aid to social work."

workers). Some were confused about how it would affect themselves and nearly all were opposed to the idea of becoming generic social workers. Though only one went so far as to say

> "I don't want to continue in social work after April 1st*. I will not fit in as I am not professionally qualified. I feel very strongly about it - there is hostility in this office. I don't want to join BASW as it will divide the qualified from the unqualified - to be only an associate after 30 years, when somebody who has only been in for three days can be a full member - no, it's not for me" (3211).

Thus, the welfare workers can be seen as representing an approach to social work that in its own terms was 'anti-professional'. As one of them commented

> "I get depressed when I hear so much talk among the young social workers about wanting to be 'social workers' or 'psychiatric social workers' or be 'professional' - I am simply me and that's all" (3501).

In this respect at least, there were parallels between these social workers and the dissidents in their attitudes towards their own profession. However, in other important respects there were sharp contrasts. The importance of outlining the components of welfare worker category in this way can be shown when contrasted with that of the therapists.

The Therapists

The term 'therapists' was chosen to describe the largest group of social workers, because quite simply this group of social workers appeared to attach the greatest importance to their therapy work. Some indeed talked of themselves as being therapists rather than social workers and thus it seemed the most appropriate term, although as will be shown further on in this chapter and also in Chapter 9 there were other staff

* The date when this particular local authority was 'going generic'.

who also considered themselves to be therapists. Like the eclectic psychiatrists and the professional psychologists, the therapist social workers took an inclusive approach to their work, and thus tended to dissociate themselves from those social workers who limited themselves to certain activities. This did not mean though, that such social workers did not consider their 'welfare work' to be of no value.

There were several lengthy quotations from such social workers about their essential tasks with frequent mentions of 'doing family casework', or having a 'special understanding of the family' or of acting as 'therapist for the family', or being 'supportive for the family'. Some times this was generalised to include all the 'social and emotional side of the patient' and sometimes included reference to being a 'therapist for the patient'. Not that such social workers excluded giving practical assistance, although this was more likely to be talked of as 'making the fullest use of social resources' (3500). One quotation, out of many possible ones, can be given to illustrate the range of activities the therapists considered they should be involved with

> "I would like to see it in terms of doing group therapy, individual casework, supplementing the psychiatrist's assessment work by getting social histories, seeing relatives, sometimes for therapy but at other times so as to get information. I also see it in terms of familiarity with other agencies and any resources appropriate for the care of the patient. Within this I include follow up work, though I react against being expected to check on whether or not patients are taking their medication. Social workers are not lay nurses. For myself, my personal interests are conducting therapeutic, casework relationships in either marital, group or on individual therapy" (3505) (1).

There were some therapists who appeared to wish to dissociate themselves from their traditional welfare work and referred to it as being burdensome. However, there were others who invested some practical activities with a

(1) He also went on to talk about how he considered himself to have a 'consultancy role' with outside agencies, such as Health Visitors and voluntary social work agencies.

therapeutic meaning. 3601 considered that "interviewing clients can be a form of therapy", while some others thought social workers were more proficient than other staff at interviewing in general, and of relatives in particular. Some therapists mentioned how they were involved in some of the activities of the Therapeutic Communities in which they worked, such as 3512 who took a relatives group and joined in art therapy and psychodrama. However, most of them thought social workers had nothing special to contribute, other than being 'therapists' in the same way that other staff were also therapists (1). In a more general way, some therapists mentioned how they had a 'training' or 'educative' function in making the other staff more aware of 'social factors' and the 'patient's outside life'. Overall then, the therapists can be seen as claiming to be 'experts on the family" (3506), practitioners of 'psychotherapeutic casework' (3207) and as knowledgeable of the wide range of available social resources.

Following from their view of their own expertise, most therapists consider social work to be essential for the treatment of mental illness even if many of them expressed qualifications about the limits of their abilities. This reflected their view of the role of the psychiatrist and their own relationship with them. Some thought that they were treated as auxilliaries, but that they ought to have a more complementary relationship with regard to psychiatrists. Many were critical of the psychiatrists for their failure to be concerned with anything other than 'symptoms' or physical manifestations of disturbance (2). But they nearly all considered

(1) The principal social workers at Woodlands did say that social workers 'may be able to offer a relationship that other staff have failed to offer'.

(2) The L/A social workers, who had the least contact with the psychiatrists were the most scathing in their comments. 3207 thought that only their "failures went to the mental hospitals to be contained and tranquillizeds by the pill pushers". Or 3203 "We do the work of the psychiatrist. That is, we do the therapy whereas they just do the pill pushing".

that the psychiatrists should decide upon the diagnosis and upon the treatment, and as the psychiatrists were "responsible", then they act as "the coordinators, and decide upon admissions and discharges" (3511). In contrast with the welfare workers who tended to see the psychiatrists as having "greater understanding of the patient's illness than anyone else, the therapists pointed to "their limitations, that arise from the narrowness of their medical training" (3204). Or made other qualifications about the deficiencies of a 'strictly medical approach', that they as social workers could compensate for. In this way most therapists considered the psychiatrists to be essential "because there are some conditions where drugs are a major means of controlling the mental illness. Without these drugs we wouldn't be anywhere" (3510) or

> "I don't think that social workers could cure or control mental illness without psychiatry. I do not go along with sociologists who say that psychiatry is no good" (3511).

Less specifically than this, most therapists also indicated how they considered psychiatry to be essential, if only for the pragmatic reasons that they felt they could not cope with the psychoses. Thus, although all the therapists saw mental illness as being more than a medical problem, such that it was also a "social, moral, psychological and philosophical problem" (3209). Many drew a distinction between the psychoses and neuroses such that

> "The schizophrenics, the psychotics, endogenous depression and the hysterical patients are medical problems, but not the neurotics or personality disorders" (3507).

In this way the therapists are like the professional psychologists in accommodating themselves to the medical profession in such a way that they themselves will be able to carry out therapy

> "over the long term. I think that things can only be achieved over a long period - I like working with patients with insight. The problems of neurotic patients or those on drugs" (3510).

This must be emphasised as being a very important dimension of the therapists mode of response. As such it can be related to the way they are aware of the context in which they work, as one principal social worker expressed it "If we choose to work in a hospital setting we must accept the limitations that arise from the psychiatrist being the head of the team" (3500). Significantly, this also has a bearing on the therapists' awareness of being directed, for as the same therapist remarked

> "There is very little direction from doctor M, I think he would let me do what I wanted with the family or the patient. We see things in a very similar way. We use the same lines of therapy in a similar way. He is aware that I won't do things that will interfere with what the doctor is doing, he has a lot of confidence in me".

Not all therapists expressed such accord (1), however, their overall lack of disagreement with the psychiatrists and the treatments that were being given, and their concern to appear moderate and able to work in 'teams', created the impression of such self-limitations and willingness to cooperate with the psychiatrists and the other staff. In such a way, many of the therapist social workers saw themselves establishing their 'professional' contribution. Many were also aware though, of the 'overlap', or 'role blurring' or even 'confusion' over the carrying out of 'therapy' or 'psychotherapy'.

As with the welfare workers, some of the therapists drew a distinction between being directed, in so far as they were asked to do things, as opposed to being supervised over how they actually did them. They were more aware of the way the legal responsibility of the doctors affected the scope of their own actions, but most of them accepted this as legitimate. As 3511 noted

(1) As noted already the Local Authority therapists were much more outspoken in their criticism of the psychiatrists, although they also appeared to hive off the psychotics for the psychiatrists. Only one of them advocated psychotherapy for schizophrenics.

"I am aware and accept that the consultant is in charge of the team and is responsible. I would not step completely out of line, though if I thought there was a difficulty I would discuss it with the consultant".

In this and similar ways the therapists conveyed their awareness of boundaries around their actions, which on their own admission they did not very often transgress.

In so far as the therapists accepted, if somewhat reluctantly, that the psychiatrists had greater responsibilities and played a more important role in treatment, then they accepted their higher status. However, several of them (especially those in the local authority) mentioned their dissatisfaction with the disparity in salaries (1). Two of the trained psychotherapists among them, mentioned their intention to take on private patients when they had gained more experience. Some thought that the reorganisation of social work and the establishing of qualifications and a register was the only way that they would raise their status and thus their pay. In this context some pointed to the "problem of the untrained and older social workers who stand in the way of our being recognised as a profession" (3209) (2). As a rule the therapists were more aware than any of the other social workers of recent developments within BASW, and while some expressed doubts and qualifications, the majority were definitely in favour of registration and of making social work more 'professional' (3).

(1) Several were extremely scathing about the way doctors doing emergency calls would get "5 gns for 5 minutes work, whereas we can spend 5 hours over a case and receive nothing extra" (3207).

(2) The majority of therapists were in fact sympathetic to the plight of the untrained, and were concerned lest they be excluded entirely from working.

(3) This question is considered in more detail in Chapter 10.

As 3507 expressed it

> "Potentially registration would be a good thing - it may help improve wages, conditions, etc. and also prevent some of the confusion over who is, and who is not a social worker. There are some do-gooders who are not professionally trained, this can be damaging".

Although the above social worker was female, it is perhaps worth noting how many of the most careerist and professionally concerned, were the few men among the group of therapist social workers. Many of the therapists were, however, opposed to the idea of becoming a generic social worker. This was particularly so amongst the Psychiatric Social Workers who in three instances dissociated themselves from other social workers by referring to how they thought of themselves as "psychotherapists, not as social workers" (3208).

Following from the psychotherapy training that some of the therapists had undergone, there was a greater awareness of the different approaches to treatment, but at the same time a general concern to appear eclectic. Among the local authority therapists there were the clearest statements of identity and hostility (1). But even among them there was an emphasis on disliking 'extremes' or 'rigid behaviourists' or whatever. (Although the local authority therapists were the most outspokenly critical of the use of ECT, and physical treatments than any of those who worked in the hospitals.) Indeed, it was only those therapists who had undergone training to by psychotherapists who identified with particular approaches. Otherwise they

(1) One who was undergoing a five day week analysis with a Kleinian analyst and who identified with the "deep psychoanalytic approach" expressed a dislike of Jungian ideas. Within the department four of the social workers had undergone Jungian analysis, two Freudian and one a Kleinian. Most simply identified with the 'psychotherapeutic' approach and then indicated their tolerance of different psycho-therapeutic approaches, while reserving their hostility for Sargant, Eysenck, and those who 'only use drugs'.

all said they did not identify with a particular approach or considered themselves to be 'eclectic'. This relates back to the way that most 'therapists' wish to accommodate themselves to the approach being taken by the medical profession. This tendency was also revealed in their view of mental illness and its treatment. With the exception of a few psychotherapists who appeared to view mental illness through a particular theoretical framework, most tended to mention a list of factors, from hereditary, biochemical imbalances, early childhood experiences, current social relationships (especially those within the family) and the wider social situation of the patient, as providing causes of some types of mental illness. When it came to the treatment, the therapists were more decisive with most of them mentioning how some form of psychotherapy was the only 'real therapy'. Physical treatments were regarded as necessary but insufficient to provide lasting 'cures' or 'insight'. In this way some of the therapists talked about

> "The training of the PSW is what makes them good at treating 'mental illness'. They are often the only people capable of sustaining a therapeutic relationship. They in fact often provide, what the patient is expecting from the doctor, but not getting" (3201).

Or as 3507 expressed it

> "Certainly, there is a need for organic therapies, but they must be used realistically. When a patient is on drugs, it doesn't mean they cannot have talking treatment. The two can go hand in hand, if the doctor appreciates that neither one thing nor the other is sufficient in itself".

Thus the therapist social workers can be seen as representing that tradition within social work that has concentrated upon the 'casework relationship', or the practice of psychotherapy as being its essential concern. Not all of those social workers who have been included within the category of therapist had undergone training as psychotherapists, but nearly all were favourably disposed to the idea of undergoing some form of psychoanalysis as part of their training. However, although a few

thought of themselves as being able to provide an alternative approach to that of the psychiatrists, most of them were concerned to stress how they could work alongside a psychiatrist, but not without one.

The Professionals

The 'professional psychologists' were those who dissociated themselves "from those psychologists who work as mere technicians" (2401). They accept that assessment is part of their job, but none would wish to restrict themselves to it. As 2601 put it "I would condemn any psychologists who did nothing but assessment". For themselves, the professionals were seeking to expand their activities invarious directions. This will be dealt with in detail in Chapter 9, so all that is necessary at the moment is to give a few examples of this tendency. Quite apart from the repeated references to the way the "BPS has defined it as assessment, therapy, teaching and research" (2400) there were several who went into considerable detail. After providing such a list, one of the principal psychologists went on to say that

> "working with ones colleagues in the clinical teams is a complete branch of the work in itself. There is also a need to be making a contribution towards the planning and policy of the hospital ... we should be offering some sort of facility with statistics for the planners. As head of department I consider my teaching-training role to be important, though contributing towards planning, may be the most important thing for me to do. I personally view my therapy work as my area of greatest interest ... I would be unhappy to exclude any of these" (2900).

Others supplemented this list, with references to "giving advice to other staff doing research, and also when changes are being made in the hospital" (2903). For many this meant they thought of themselves as having a 'consultancy' role, though others recognised that they had yet to be granted such recognition

such recognition (1). Other activities that were mentioned by the professionals as being ones that they had some expertise over, were research (especially 2500, 2501, 2803, 2804, 2601), different forms of therapy, from behaviour therapy through various forms of individual and group therapy, to depth psychotherapy. As well as this, some also fet they could "organise the management and running of wards in line with certain treatment plans" (2403) as well as being in a position to "help establish criteria on what sorts of treatment situations should be developed, and to make these criteria available" (2501). Thus the professionals can be seen to share the same inclusivist approach to their work as both the eclectic psychiatrists and the therapist social workers.

One outcome of this tendancy to consider that "we can contribute in many different ways throughout the hospital" (2904) was that most professionals noted how there was considerable overlap between what they did and what the other staff did. As 2901 pointed out

> "I see the relatives of the patients that I have in therapy, so this is not the difference between me and the social worker. The only thing that the psychiatrist does that I do not do is give chemotherapy. So I see, I don't know, a loss of boundaries and movement towards there being one generic worker for mental patients".

This quotation raises what, in many ways, must be considered the most important feature of the 'professional' ideology among the psychologists. That is, a view of the social structure of the institutions in which they work that sees them as almost lacking structure. Several commented on how difficult it was to generalise about their relations with the psychiatrists and the extent to which they felt directed or limited. One of the principal

(1) 2401 commented that "I think we entered mental hospitals in the wrong way. Instead of entering as auxilliary testers, we should have entered as independent consultants. I would like to see more psychologists using the title of consultant and to be working in a way that the title implies".

psychologists (2900) gave a very lengthy explanation of what he saw the situation to be like. Extracting from it, he talked of the psychologist being

> "an independent specialist while his role is a matter of negotiation. Not conscious negotiation, but the give and take of interpersonal relationships. I think that the psychologists who ignores that the doctor is in charge is making a grave mistake which might even be harmful. It's not a clear cut answer, but it's not a clear cut situation".

He went on to note how

> "I have never actually felt myself to be in any direct conflict about having limitations placed upon me. I think partly because I function within what I perceive to be the appropriate division of work - I don't try to take on medical decisions such as drugs, admissions and discharges, and I have never met a doctor who tried to tell me what to do ... I also feel that to ignore the setting in which you work is to have a bad effect upon your work, and besides I cannot conceive of going about with an idea of my own, without trying to link it with the work and ideas of my colleagues".

What is striking about such an account is the way there is a virtual denial of any 'boundaries' existing around psychologists other than those that arise out of 'negotiation', and a recognition of the nature 'of the setting in which you work'. The similarities between this and the therapist social workers' view of the social structure should be noted as confirming the way such professionalising lay staff view their situation. Also contained within these remarks is an affirmation of the 'team work' philosophy that one must exchange ideas and integrate ones work with that of the other staff. That this involves accommodating oneself to the 'appropriate division of work' and accepting that the "psychiatrists do have statutory responsibility", becomes apparent from the above quotations.

The wider significance of this wish to accommodate, will be drawn out in subsequent chapters. Other quotations could have been given from other 'professionals', but it was thought that a more coherent picture of this aspect of the way they view their situation could be given by simply using one person as an example. A further quotation from 2900 can be given, by way of further amplification

> "So my final comment is that I don't see the presence of other people to be a constraint, limiting my freedom, but more as realistic boundaries which more or less define and channel the scope that I have got. I don't feel oppressed by these things - they help give me an identity rather than trapping me".

There were of course differences among the professionals over the extent to which they felt themselves to be directed, some being more aware if it than others (1). A quotation from one of the other principal psychologists usefully illustrates some of the points made above and what is being taken to be the 'professionals' view of such direction

> "There are limits upon me, but only in so far as everyone has boundaries. I am aware of them, otherwise I can do what I like within the framework of very friendly and amiable professional relationships with the doctors. They have responsibility for the patients, you cannot escape this. We are not registered yet, though we are working upon it. When we are there will be greater freedom and more responsibility for us. As it is I am quite happy to do psychotherapy with the patients that I have, and its always useful to have a psychiatrist to refer patients to when I am not successful - why bother if someone else is there?" (2800)

This quotation has been given in full as it raises further aspects of the professional's ideology. On the one hand there is the concern to become registered and gain greater autonomy (2), but at the same time they welcome the presence of the doctors to take over the 'unsuccessful cases'. This parallels the distinction that many therapist social workers made between the neuroses that they could handle, as opposed to the psychoses that they thought belonged to the psychiatrists. Many professionals noted this distinction themselves, and often noted how "physical treatments are necessary, if undesirable in the treatment of the psychoses" (2601). Thus the professionals tended to believe that the psychiatrists were essential, even if they went on to detract from the latters' expertise by such remarks

(1) Examples of those who were more aware of it, will be given in the section on the social structural position of the lay staff.

(2) This is considered in Chapter 10, pp.308-311.

as

> "Well, apart from pushing drugs into people, which is necessary, and only they can do, most of the rest could be done by other members of staff, just as well, if not better. At least social workers and psychologists are not hide bound by a narrow medical education" (2505).

In this and other ways the professionals certainly made critical comments upon the 'limitations' of the psychiatrists, and their 'inability to see things in other than a medical way' (2402). Some were even quite scathing, about their "incompetance at recognising physical factors and carrying out routine GP functions" (2401). While 2403 refers to psychiatry as "the bastard son of medicine that should never have been born". Significantly, all these comments come from the Oakdene (subnormality hospital) where there was greater antagonism between the psychologists and the doctors than at any other hospital. The majority of professionals in contrast with those at Oakdene, were very moderate in their criticisms of the psychiatrists and indeed stressed how conscious they were of the problems facing them (1). Like the therapist social workers though, they tended to differentiate between 'real' therapy, which they usually took to be a form of psychotherapy, and 'treatment' which was often taken to be provisional and of a palliative nature. One of them even thought that "Many of the younger doctors look to us to tell them about the patients. They tend to feel that psychologists know more about therapy and the psychological aspects of the illness than they do" (2904). Others thought that "we are able to give the more lasting therapy", as 2902 put it. In fact among the psychologists in general and professionals in particular, there were indications of the ideological divisions that have been observed so often by other researchers (2). This

(1) Such as having to maintain a turn over beds and treat many patients as rapidly as possible.

(2) Among the professional psychologists for example, there were references to identifying with 'The Neo-Freudians', 'Jung' and the 'Jungian Approach' as well as with 'Kelly and Construct Theory'. Several combined various approaches such as 'learning theory, Jung and the more mystical approaches as well as the organic'. A few mentioned 'behaviourism' but only one wanted to be identified with this approach. Significantly, there were very few references to Freud, a fact that provides further evidence of the lack of sympathy for his ideas among many British psychologists. (As a rule the psychiatrists mentioned being influenced by Freud much more than the psychologists did.)

meant that some were more definitive in their criticisms of the medical profession and other psychologists, yet at the same time stressed how it was only 'extremes' that they really objected to. It is important to stress how the professionals, while being critical of the medical profession and certain 'medical' therapies, were at the same time moderate in manner, and conciliatory in tone.

Such moderation appeared to stem from their general 'eclecticism' towards the treatment of mental illness. Many of the professionals stressed how 'nothing should be excluded' when considering the possible causes of mental illness. The majority of such psychologists displayed a preference for seeing mental illness as stemming from social - psychological processes such as a 'breakdown in relationships', 'maladjusted learning processes', 'traumatic loss', or 'childhood deprivations', but even so, nearly all such psychologists stressed how no single explanatory framework was adequate on its own. One consequence of this tolerance for 'whatever works', being the way most professionals stressed how they accommodated themselves to the use of physical therapies, even when they did not agree with them. Indeed, the majority of professionals noted how rarely they disagreed with the sorts of treatment being given.

This low level of disagreement was commented on by 2906 who observed that "I have never heard of a psychologist confronting the psychiatrists head on" (1). While 2800, one of the principal psychologists thought that those psychologists who run into trouble with the psychiatrists often

> "lack maturity in approaching the psychiatrists with open rebelliousness and resentment. It becomes a self-fulfilling phrophecy, they approach

(1) This should be related to the self-limitations that such psychologists place around themselves. This is explored in Chapters 9 and 10.

the psychiatrist in the wrong way expecting to be rejected, well then they are" (2800) (1).

Other professionals displayed a similar concern to appear able to get along with the psychiatrists. Indeed, one of the other principal psychologists talked of how the most important aspect of a psychologist's training was

> "Learning to be a professional person in the true sense - to be able to tolerate uncertainty and conflicts within ones own profession. This also means being involved with other disciplines, learning to work alongside them as a professional with something to contribute, yet respecting the people you work with, even if you dislike them as individuals" (2400).

Many professional psychologists appeared committed to the idea of working in 'teams' as a way of making a more valuable contribution. How far they were able to make such a contribution as well as other points raised in this section will be explored further on.

The Testers

As already noted, the psychologists showed the fewest divisions among themselves. In many ways the tester mode of response, that is about to be described, cannot be seen as comprising as many elements as the doctor or welfare worker categories. Certainly, there are similarities between all three of them and particularly over the way they take a more limited, almost exclusive view, of their tasks in a way that contrasts with the inclusivist tendencies of the 'eclectics', 'therapists' and 'professionals'. The term itself derives from the way such psychologists stressed their testing work

(1) This reveals another component of the professional ideology in particular but also expressed by other staff, that problems in working relationships are mainly due to either personality problems or inadequacies.

above all else. This found clearest expression in the words of 2700

> "The most essential thing is to be a good diagnostician. Soon after I came here, I realised that this was what was needed. I made it my duty to see that the doctors were so completely satisfied with what I have to offer that they dare not, not use my services. So diagnosis forst and foremost, then teaching, then research, to be followed by therapy at the end. What's important for the young psychologist today is to learn to write really full and detailed assessments and reports on patients that the doctors will listen to".

The significance of this view of the psychologist's work will be more in Chapter 9, when the attempts of the majority of psychologists to shed such assessment work will be considered.

In many ways all that need be said about the testers has been said in the above quotation. What is clear is the emphasis on assessment, even if other activities are also engaged in. Thus one of the other testers, who also noted how he saw some patients for therapy, and did some teaching, observed that

> "The diagnostic part is the most important, If I see a case and give the fullest investigation, I will see them for six hours, whereas the doctors will only see them for half an hour" (2701).

It is not as if they do not do therapy, although 2700 did comment that

> "I am an expert in diagnosis and I don't make decisions other than this. I don't consider myself qualified to do therapy. I don't know how anyone dare start unleashing and playing about with people's unconscious, without first having a very thorough training. The trouble is that there are too many people who want to do therapy without having any idea or training in what it entails".

One of the other testers, while not expressing himself so forcefully, dissociated himself from those "staff who are so anxious to be doing therapy" (2600) (1). In some respects the psychologists within the Oakdene hospital were closer to the testers than the professionals in their descriptions of their tasks. In particular they attached more value to

(1) Which he considered "To be largely a matter of middle class values being imposed on often willing, though occasionally unwilling patients".

assessment work than most other psychologists, but in other ways they were more like the professionals.

Apart from these differences in their view of their work, the testers were not all that different from the professionals. They appeared to want psychology to professionalise, although none were interested in the recent developments. They did, however, perceive a clearer division of labour between themselves and the other professionals while at the same time considering treatment to be largely the province of the psychiatrists [redacted]. Stemming from this they viewed psychiatry to be essential for the treatment of mental illness, although 2600 was sceptical of how far anyone understood anything about it. He commented though, upon the indispensibility of drugs

> "Just imagine what this hospital would be like without the doctors to prescribe the drugs. Wards that were bedlam twenty years ago are now as hushed as cathedrals" (2600).

The Dissidents

Although attention has been drawn to the way that there were similarities between the doctors, welfare workers and testers, and likewise between the eclectics, therapists and professionals, it was among the dissidents within the three professions that the greatest unity was shown. Indeed, almost a characteristic of the dissidents was their wish to break down the occupational divisions among the staff. As one of them noted with reference to the question of there being separate departments

> "I am against this - to split up into departments means that the social structure of the hospital becomes very stable and resistant to

> change. Your reference group becomes highly restricted and you are likely to feel contented with your lot. It takes someone with a lot of rebelliousness to get out of this. I have managed this with the people that I work with - they now see me as a person not as a psychologist. The only way that people can cope with this is for a group of staff and patients to really work together, to overcome such segregating categories. Some staff who tried to work with us became very anxious because they felt they were loosing their professional identities. Most of the people who work here, in fact, need their professional ideologies to cope with the great deal of uncertainty and nastiness that there is to cope with. So even if you broke down the present structure you would find that these divisions re-emerged for people to hide behind" (2801).

This quotation has been given in full as it provides a useful introduction to the dissident mode of response and points to several ways in which they differed from the other staff. Many other staff for example talked of a need for 'team work' and 'breaking down' disciplinary divisions, but where the dissidents differed was in going beyond this to argue for the disintegration of their own occupations in particular, and of specialisms in general. This view found expression in various ways, and reflected an overall anti-professionalism that marked the dissidents from the other staff. Other points from the above quotation that will be elaborated below, are the greater awareness of 'structural' factors affecting social relationships, the call for staff to 'work together' with patients, in a way that many other staff would consider to show 'over-involvement', and a self consciousness of being 'rebellious'.

To begin with the anti-professionalism. All of the lay dissidents were either opposed to the moves to make their occupation more professional or else expressed considerable misgivings about them (1). Several expressed their opposition in terms of the irrelevance of them for the work that was involved. One of the social workers said that

(1) This issue is explored in some detail in Chapter 10.

> "A lot of the qualified and professional people may have academic, factual and external knowledge, but this often has nothing to do with it. Instead they use their professional qualifications to hide their own lack of personal qualifications. It's useful to have some techniques and knowledge but they are wasted if you don't have an understanding of yourself" (3503) (1).

In other ways, some of the dissidents talked of "being tempted to say that everyone has the qualities to treat and understand patients, without being sure precisely what these qualities are" (2502). Other staff also made frequent references to how personality factors were often the most important determinant of success as a therapist, but where the dissidents differed was in their wish to involve themselves with patients as individuals, not as staff members. Stemming from this there was a belief that anyone not just the qualified, could understand mental illness

> "You don't need to be medically qualified or have a knowledge of academic psychology to understand what happens when a person breaks down. It's much more a matter of who you are rather than what you are. The real work in a place like this is being your real self with patients. If you cannot stand suffering then you are no good - you cannot help anybody" (2802).

Further, the traditional 'distance' and 'neutrality' of the doctor-patient relationship were considered both undesirable and unattainable. As one of the psychiatrists put it

> "The idea of the purely passive role is a myth, as is the claim to be neutral. The whole of psychiatry is one big value judgement, although in practical terms one should try and have open, honest, direct relationships with them as people" (1516).

The other psychiatrist went so far as to say

> "I might consider sleeping with a patient, but this would depend on what seems appropriate. If it helped towards understanding the person as a person, in their own terms, instead of in some psychiatric

(1) One of the psychiatrists talked of this need to understand oneself in terms of "... cultivating humility in a religious sense - this sounds hypocritical but this may be what is needed. To involve oneself in a way that deals with other people - to search oneself - this is difficult for everyone. In many ways to be mad is to be more sensitive. It was a need to understand myself more fully, so as to be more sensitive towards others, that took me into psychiatry" (1511).

category, then it means getting involved with them. I can learn from them, as well as they from me". (1511).

In other ways, this anti-professionalism took the form of criticising those who were seeking to turn these occupations into professions. As one of the social workers expressed it

> "I don't like the people that work in social work and I don't like the way some of them think they can create a profession out of it. At the moment it hasn't got the theory behind it, the ethos or the techniques to be a profession. As social work stands at the moment, it is and ought to be, only common sense and administrative know how" (3603).

Thus, another feature of the dissidents was their scepticism towards those, who in the words of the above social worker "are trying to take over the psychiatrists job in the form of psychotherapy". Such criticisms of psychotherapy will be returned to below; before doing so, a comment by a psychologist can be given to illustrate this further "I neither associate with, nor approve of those psychologists who are trying to make us appear more 'scientific' so as to raise our status" (2504).

This raised the question of where the dissidents believed their expertise to lie. For, while there were some who wished to be more involved as therapists, there were others, like 3603 above, who dissociated themselves from such activity. Others expressed the view that

> "As far as I am concerned anyone can do therapy. I have known a ward maid who was a better therapist than many psychiatrists" (2801).

Several stressed the value of direct practical help for patients, as one social worker put it "Home helps can be a lot more use to many patients than any amount of psychotherapy" (3212) (1). Although there were others

(1) Some also criticised psychotherapy "because of the way its practitioners tend to locate the fault or weakness within the individual rather than within the wider social structure" (3603).

who believed that they should be intervening in families, in a way that showed the influence of such writers as R. D. Laing and A. Esterson. Overall, however, the dissidents did not appear to differ from their colleagues in their conceptions of their expertise. Certainly, this was not an area in which to differentiate them, in the way that the welfare workers, for example, could be. Interestingly, though, the dissidents often took a more restrictive view of their expertise that in some ways differentiated them from the eclectics, therapists and professionals. This may in part reflect the lack of faith many of them expressed in their occupations. As one of the psychiatrists remarked

> "Your central task is usually making someone adapt to his situation. This often means using physical methods to make them adapt. The only unique expertise that we possess, relates to the treatment of organic factors, which are rare, and to the use of physical methods. These are used all the time but with little success other than getting people to adapt" (1516).

Or as one of the psychologists commented

> "I cannot think of anything that I have done that was absolutely essential, neither can I think of any work done by any other psychologist, or any technique that we possess that is essential. I think the profession is a bastard profession" (2801).

The dissidents were also more likely to comment on the way they were 'irrelevant' or merely regarded as 'messenger boys', 'fact collectors' or 'technicians', within the existing hospital structure (1).

These comments raise a further important dimension of the dissident mode of response, namely their greater awareness of being directed or controlled by the medical profession (2). Whereas most of the other staff emphasised how, even when aware of such direction it did not interfere with

(1) Or as 2503 put it "I might as well not be there, as the doctor that I work with sees no need for a social worker".

(2) This question is explored in more detail in Chapter 10.

their work, the dissidents showed evidence of resenting the 'boundaries' around them. As one of the social workers expressed it "The doctors are a sort of blockage, they prevent me doing the sort of things that I would like to be doing" (3503). The two dissident doctors both expressed a wish not to be put into leadership roles. One blamed this on "the authoritarianism within our society that inclines doctors to believe that they must be in control all the time" (1511), while the other expressed the view that "The doctors should not have this power at all. Instead, all decisions should be worked out on a genuinely democratic basis" (1516). This was a view that was echoed by several other dissidents (1).

Underlying their opposition to medical direction, the dissidents were also expressing more outspoken criticisms of the medical model of mental illness, than any of the other lay groups. One psychologist said that

> "The whole medical thing has got to be escaped from. People are no longer evil, but sick. This is bad as it makes it easier to say that you need medical help rather than spiritual or social or political or whatever help" (2502) (2).

Their criticisms of the medical model and of medical therapies were more far reaching and fundamental than those of the therapists or professionals. Implicit within them there was often the element of an alternative way of looking at mental illness. Significantly, many of the dissidents objected

(1) One dissident psychologist thought that the most important thing for the psychiatrists to do after they had broken away with being 'guardians of the communities' interests' was to "try to institute a more democratic process of decision making about patients" (2906). It was also among the dissidents that there were the most frequent expressions of the view that psychiatrists were hardly necessary. As 3606 expressed it, "There is no need for a doctor, except for one person with a good knowledge of drugs. A well trained P.S.W. could run the lot - their training is more appropriate than that of the doctors, they at least know about human relationships".

(2) Many dissidents, like other lay staff, thought it appropriate to call mental disturbance an 'illness' so as to reduce the stigma attached to madness - see Chapter 8.

to the use of the term 'illness' in the interviews. One of them went on to say

> "Illness is a signal, if it's truly understood and appreciated and given its due. It can be healing for that person, if it's not passed on to the doctor to 'cure'. Psychiatrists get in the way of the treatment of mental 'illness'. Most of them prescribe drugs that stop it happening or give ECT that has such unpredictable side effects. Most doctors think that the meaning of an 'illness' is the life of the patient and that is all" (3513).

More explicitly, many dissidents talked of how they wished to see mental illness as 'a valid form of human experience'. One of the psychiatrists observed that

> "I am often quite jealous of patients who have been psychotic and yet have coped with it. I feel they have had experiences that may always be denied to myself" (1511) (1).

Although ill formulated, and somewhat confused, the dissidents appeared to be seeking for an alternative way of looking at and explaining mental illness. Many made references to the work of the 'anti-psychiatrists' as providing the theoretical grounds upon which to attack not only the medical profession, but also their own. To quote one of the social workers

> "I agree with David Cooper when he talks about the violence that is inherent in psychiatry. The same applies to social work, only it's less apparent as we are trained to be more understanding and supportive" (3504).

In particular many made references to the general role of psychiatry as an 'agency of social control' (2). One of the striking features of the dissident mode of response was the view that "social workers are often acting as undercover policemen" (3503), or that psychiatrists were the "mind

(1) He went on to suggest that to have been psychotic would be a useful experience for working in psychiatry. This sharply contrasts with the 'doctors' view of such experiences or the qualities required of a good therapist.

(2) One dissident psychologist welcomed the way the Gay Liberation Front were openly challenging "the definitions placed upon them by psychiatrists. There is a need for other similar groups to combat the way their experiences are invalidated by those who claim to help them" (2804).

police of our society" (2801). This stands in sharp contrast with the way nearly all the other staff, whether medical or lay were concerned to present themselves as being 'therapists', or as 'concerned with the welfare of the patient' as if they were never involved in controlling or restricting the patients' behaviour. As already noted, the dissidents were generally opposed to the way that seeing madness as illness, led to its extrusion from the social context that created it, into a hospital where it would then be treated.

While not all the dissidents saw mental illness as being 'caused' by society, there were several who would have agreed with 1516

> "I would like to see it in terms of the evils in society, but one does meet up with people whose conditions cannot be explained in these terms. However, while accepting there are some organic conditions, I oppose the ideology that this approach and that of some psychoanalysts engenders. This leads to a right wing view of man such that the fault is always located within the individual and rarely if ever with the wider society. Instead you must be able to see how people are thwarted by the society in which they live, and how this society creates the deviance that we label 'mental illness'. What is required in a word, is a left wing analysis of society".

Other dissidents expressed more voluntaristic theories of mental illness, such as 2801, "I think that most patients can decide for themselves what to do and usually do so anyway. The psychiatrist only validates someone elses decision". And others noted how they were attempting to

> "look beyond seeing things in terms of 'illness' or 'sickness', to see the 'patients' as people who are disturbed in their emotions or whatever. This doesn't create the necessity for separate roles, although we are still hindered by the fact that the doctor is seen by the society and often the patient, as being the one to 'cure the patient'" (2802).

One possible alternative being suggested by one of the other dissident psychologists was that

> "... being 'mad' should be a way of life, that can be considered feasible for those that want it. I find it very disturbing how doctors and 'eminent' people can act as experts in deciding how other people should live ... what we need are small units or sanctuaries or retreats

where people know there is some sort of knowledge and experience for them".

The influence of the 'anti-psychiatrists' on the dissidents has already been noted. This influence was further reflected in their 'identification' with existentialist writers. Many of the dissidents gave the most detailed accounts of the writers who had influenced them with names ranging from some of the established figures such as Freud, Jung and many of their followers (especially some of the Neo Freudians), to Binswanger, May, Laing, Cooper, Esterson, and on to a range of others such as Alan Watts, Timothy Leary, Anton Artaud, as well as some sociologists such as Goffman, Scheff, and the symbolic interactionist writers. Quite apart from the different range of names, the very fact of the dissidents mentioning as many as they did, contrasts them with the other groups and especially the doctors and welfare workers.

Other references will be made to the dissidents in the course of analysing some of the broader issues. The purpose of the foregoing was to draw out the main features of the dissident mode of response. In some respects they did not differ from the other staff. They also frequently found themselves adapting to, and accommodating themselves with, the situation in which they were working. However, in contrast with the others, many dissidents expressed the view that they were finding it increasingly difficult to continue working within psychiatry. Some reported the pressures upon them from their own senior staff to take up 'more suitable work', while others intended leaving in anticipation of trouble in the future (1).

(1) One of the psychiatrists reported how his consultant had told him that he 'lacked maturity, and clinical judgement in over identifying with the patient', and how he was not 'suitable for the stressful nature of psychiatric work'. It is known that at least eight of the dissidents have subsequently given up working in psychiatry.

Conclusions

The ideological types that have been described in this chapter, gradually emerged and developed the shapes they have been given over a considerable period of time. They were initially discerned during the field work and were developed during the analysis of the interviews. Certain attitudes expressed by collections of individuals who were often working in different situations, drew attention to underlying similarities of outlook. Further, a problem developed of how to reconcile what often appeared to be quite contradictory descriptions and evaluations of the same situation. For example, social workers attached to the same teams and therefore in contact with the same psychiatrists, sometimes assessed the amount of direction over themselves quite differently. Or psychiatrists might talk of the social workers 'being absolutely essential members of the team', yet appear to consider that only themselves, as doctors, could provide any effective treatment with physical methods. Similarly, there were psychologists who seemed to be both critical of the 'deficiencies of the medical profession', yet who stressed 'how well' they worked with certain psychiatrists. In these and in many other ways a series of different contradictions were being expressed, yet without any apparent incongruity being felt by the staff concerned. It therefore appeared for example, that the extent to which a social worker or psychologist felt themselves to be 'directed' or 'restricted' by the psychiatrists, could not be considered in isolation, but only if due reference was given to a series of apparently inter-related assumptions that have been drawn together to make these ideologies. In other words the 'definitions of situations' being made by different staff had to be taken seriously, as such definitions appeared to be having 'real' consequences that were not always noticed by the definers themselves.

The typologies that have been presented, have in many ways extenuated and exaggerated the differences between the staff, as in the process of selecting the quotations, the more expressive and illuminating and thus 'extreme' were often chosen in preference to the more moderate and less expressive (1). One of the tasks of the subsequent chapters will be to draw attention to what appeared to be an underlying consensus over certain questions. For example, the way nearly all the staff accepted that the treatment of mental illness had to be seen as a partly, if not wholly, medical problem, and the consequences that such a consensus has on the structure of relationships between the occupations.

These ideological typologies contain within them certain important clues to the professional processes that will be analysed in more detail further on (especially in Chapter 10). There have already been several references to the problems of identifying the nature of the expertise to be used when treating mental illness, and how many staff personalise ability as a therapist. Further, the way the lay staff appear to have considerable autonomy over their actions, appears to be related to the maintenance of particular relationships with sympathetic and 'like minded' psychiatrists. The way the psychiatrists withold 'professional recognition' for different reasons and the 'limited' recognition that most of the lay staff grant the psychiatrists, have also been referred to. While the way many of the staff accommodate themselves to the 'reality' of the situation that they are working in has been noted. There also appears to be some opposition within the lay occupations to the 'professionalisation' of their occupations. Traditionally, theorists of the professionalisation

(1) Although an important element of the eclectic/therapist/professional ideologies was the way they stressed how 'moderate' they were in their claims they made about their own profession, and further how they disavowed 'extreme' ideas and practices.

process have suggested that such elements are eventually cast off by the more successful, but as this anti-professionalism appears to be reflected in wider social movements, it may not be a dying element within these occupations (1).

The ideological types that have been identified would not appear to be segments in the manner described by Bucher (1969), for they are not necessarily conscious of one another or think of themselves in the terms in which they have been described. However, the divisions that have been identified do parallel in various respects the divisions that exist within these occupations, and which were referred to in Chapter 4. The numerical superiority of the 'therapists' can perhaps be accounted for by the settings in which the interviews were carried out, and the stage of training of many of the respondents (see Chapter 5) (2). But it is also believed that their ideology and the points at which it differed from that of the therapists can be found in the existing social work literature. The same can be said for the other occupations, although it is also believed that the quotations given in this chapter and subsequent ones, often reveal facets of these occupations not normally referred to by their 'spokesmen'.

In Chapter 1 it was pointed out that this study was conceived of as an exploratory one that aimed at initially providing a description of the current structure of relations between the three 'rival' mental health professions. The task of description proved to be more complicated than expected, particularly as many of the members of these occupations denied that there was any rivalry or conflict between themselves and the other

(1) Such as the upsurge in student radicalism. This was noted in Chapter 2.

(2) It should be noted that social workers more than either of the other two occupations, find their tasks to be defined largely by the agency function.

occupations. As already noted, such assertions drew attention to the need to interrelate the varied ways in which different staff, defined their own situations. They also drew attention to the need to consider the role of such socially grounded ideologies, in the articulation of the professionalisation process. If large sections of an occupation define themselves in an auxilliary and accommodative relationship to a more dominant one, then this has consequences not only for the professionalisation of that occupation, but also for the theories that sociologists develop to explain this process.

The next chapter will contain a restatement of what are taken to be the common elements underlying the psychiatrists' defence of their claimed medical mandate to treat all forms of mental illness as well as physical illness. It is necessary to deal with these claims in some detail because of the consequences for the professionalisation of the lay occupations.

CHAPTER 7

THE MEDICAL MANDATE

Summary: This chapter is divided into two parts; the first provides an outline of the main components of the medical mandate, while the second part examines the implications of this mandate on the view that psychiatrists take towards the lay staff. The medical mandate is taken to be comprised of the belief that mental illness should be regarded as a medical problem, the belief that psychiatry is essential for the treatment of mental illness, and the assertion that the medical profession should have overall direction of the treatment and care of mental patients. These issues are considered separately, but are then combined in an examination of the psychiatrists' view of their own expertise. In the second part, there is a description and analysis of the nature of recognition that the psychiatrists give to the lay staff. The different evaluations made of the social workers and psychologists and the reasons for these differences, serving to illustrate further dimensions of the medical mandate. Throughout the chapter references are made to the ideological types, and the bearing that these different outlooks have on the issues being considered.

Introduction

In Chapter 6 descriptions were provided of three different types of psychiatrists and of the ideologies that serve to sustain the way they view their role. The differences between these groups were necessarily exaggerated in the process of describing them; the points at which these ideologies merge and coalesce having been inevitably obscured. The

ideological categories were developed because of the evident contrasts between the psychiatrists that were interviewed; these contrasts being particularly evident in the attitudes they expressed towards the lay staff. At the same time, however, it is believed that with the possible exception of the dissidents, the psychiatrists were united in making certain claims, even if the rationale behind these claims differed. These claims comprise what is being termed the medical mandate. This term has been adopted from Goffman (1968), who has used it extensively in his analysis of the psychiatrist's role in mental hospitals, without ever defining precisely what he means by this term (1). The very diffuseness of the medical profession's claims to be able to treat all manner of physical, psychological and even social ills making a precise definition difficult. However, for the purposes of this study the medical mandate is to be a series of inter-related assumptions and claims that serve to justify the present dominant position of psychiatrists over the treatment of mental illness. Stated in the order in which they will be dealt with, these claims are firstly that mental illness should be regarded as being a medical problem, even if it is recognised as being more than that. Secondly, that psychiatry as presently constituted, makes an essential contribution towards the treatment of mental illness. The importance of this claim being the supremacy claimed for psychiatric knowledge over other knowledge. Thirdly, and strategically,

(1) He would appear to have borrowed this term from E. C. Hughes, though there is no reference to Hughes work. Hughes (1958) talks about occupations that "claim a mandate . To define the proper conduct of others towards the matters concerned with their work ... it may, as in the case of the modern physician include a successful claim to supervise and determine the conditions of work of many kinds of people" (p.78). He goes on to note how "professions, perhaps more than other kinds of occupations, claim a legal, moral and intellectual mandate ... Indeed they set the very terms in which people may think about this aspect of life" (p.79).

the most important of all, there is the claim that there should be medical hegemony or leadership over the other staff. Finally, there are the various claims made about psychiatric expertise and the extent to which both technical and indeterminate skills are held to be the basis of the psychiatrists' superior 'clinical judgement'.

One of the consequences of the medical mandate being claimed by psychiatrists is that they can decide "who does what, to whom and with what" (2500). This means that the lay, ancillary staff are only able to fulfil their own claimed mandates, if the psychiatrists accept that they have a relevant and worthwhile contribution to make. For this reason, it is appropriate to consider the nature of the recognition that the psychiatrists extend to the lay staff. Not only are further elements of the medical mandate revealed in this way, but also the ideological differences between the psychiatrists can be highlighted in such a way as to cast light on the problems that confront the lay staff. The structurally dominant position of the psychiatrists enables them to oversee and thus 'supervise' the activities, or rather the boundaries of the lay staffs' involvement in the treatment of patients (1). If professionalisation is taken to be about the establishing of control over the application of certain knowledge, then it is important to consider the way those who have established control, seek to defend it from possible rivals.

Throughout this chapter, as in subsequent ones, there will be frequent references to the previously described ideological types. However, the analysis will not be in terms of these ideologies, but rather will make

(1) This statement must be qualified by reference to the way many lay staff felt there was 'no supervision' over them. This will be dealt with in some detail in Chapter 10, and it has already been referred to in the analysis of the ideologies in the previous chapter.

reference to them, in order to point to the evident differences between the members of each of the occupations, while at the same time drawing attention to the similarities in the constraints that are acting upon these occupations.

Mental illness as a medical problem

Of the 38 psychiatrists interviewed, 29 could be considered as clearly believing that mental illness was a medical problem, while 9 appeared to be equivocal. Among the former there were several who suggested that it was more than a medical problem but also many who simply asserted that "It is, and should be" (1600) without going into any more detail. For some psychiatrists mental illness was a medical problem because in the words of 1603

> "It has to be in the hands of the medical profession because of the problem of diagnosis, so many problems are caused by physical illness and organic conditions, that this side must always be kept in mind".

This 'doctor' went on to say that

> "It's absolutely essential for a psychiatrist to be a good physician, to have ones membership of the Royal College of Physicians. The more extensive your knowledge of medicine the better, there should be no question of psychiatrists being anything other than doctors".

To place such emphasis on medical knowledge being essential, and in particular on the need for the psychiatrist to diagnose, is to justify psychiatry in traditional medical terms. Some other doctors asserted how mental illness was 'an illness' and therefore a medical problem. However, others were less assertive and talked merely of the possibility of there being a physical illness. As 1520 put it "Some psychiatric illness is associated with physical illness, such as dementia from pneumonia and is therefore a medical problem in that sense". Others referred to the

'problem of considering the side effects of drugs', and to the problem that

> "If there were no doctors then the patients would have to be sent for routine physical examinations. This would be expensive and time consuming and nobody would want the job. Also, I do not think that lay people can take over the responsibility for the administration of drugs" (1507).

For another doctor, it was the specific use of drugs that made mental illness a medical problem "It has to be because of the problem of the psychosis. If you treat psychotic illness you have to use drugs, and we are the only people who know about them" (1509). There were also some who made 'holistic' claims such that

> "you cannot differentiate between mind and body. If the person is anxious, his body is affected, they are interrelated. All psychiatric illness affects the body, the body affects the mental condition, so psychiatric illness is a medical problem. People have called the mind a tissue" (1512).

Of the psychiatrists who were more equivocal there were some who talked of the problem of whether or not the neurosis, or personality problems were medical concerns. One pointed out how they could not cure them but that

> "at the present time the assumption is that these are medical problems, but one must not be rigid about it. In the future some things may be split off, so they won't require a doctor, but the initial screening must be done by a doctor to eliminate the medical conditions" (1501).

Some psychiatrists suggested it was a question of 'others' expecting them as psychiatrists to regard the patient as being ill. One doctor talked of "The boundaries of medicine are very diffuse, the traditions of medicine are respected and trusted by the general public. It cannot work any other way" (1513). More specifically, another talked of how

> "Mentally ill people cannot be treated without psychiatry. Anyone who is diagnosed as suffering from a mental illness, must be seen by a psychiatrist ... psychiatry is a medical specialty, so obviously he is the one to deal with mental illness" (1404).

Thus, although there were a few psychiatrists who talked of "the limitations

of the medical model" (1510) or the need to see it as also a 'social problem' the majority were convinced that mental illness was first and foremost a medical problem. That many psychiatrists believed that the need for 'medical cover' meant that they also took charge of 'everything and anything' about the patient can be illustrated from the following quotation

> "It should be, though in practice it is society that has decided this, it's not one's own choice. With some conditions it cannot be otherwise, but for the care of the acutely ill and disturbed psychiatric patient, the doctor must have the final say. Whatever, you see as causing mental illness, and there are some organic conditions, all people with a psychiatric disturbance must be vetted by a doctor first. So in this stage the doctors must have overall control as many of these conditions are not recognisable to someone without his training. Then large sections of mental illness can be treated with physical methods and you need a doctor for this. The introduction of the phenothiazine has been the greatest advance in the treatment of mental illness, even if we are still only controlling certain mental states rather than curing them" (1506).

This quotation has been given in full as providing a good example of this claimed medical mandate. Not only is there the claim the 'others' have put the doctors into a position of leadership, but there is the assumption that because some psychiatric illnesses are organic in origin, that <u>all</u> patients must be vetted by a doctor first. Not that such vetting takes an advisory form only, but is taken to be a preliminary to treatment with drugs, which only psychiatrists can prescribe. These drugs are further claimed to be efficacious, as if this was beyond dispute. The legitimacy of the medical model is so taken for granted, that it is only natural that the psychiatrist should have the final say, as he would in the care of physical illness. Above all there is the assumption that it is the right of the psychiatrist to extend his mandate to treat physical illness, so as to decide upon the relevance of his own and the other staffs' contributions, even when there is no physical illness present.

Psychiatry as THE treatment of mental illness?

The psychiatrist quoted immediately above clearly believed psychiatry to be essential for the treatment of mental illness. It would indeed have been surprising if many psychiatrists had denied the value of their own specialty. However, the question cannot be left there for the justifications given for believing it to be essential provide further insights into the nature of the medical mandate. The previous chapter has drawn attention to the differences between the psychiatrists and in particular to the way the eclectics were less assertive and rather more equivocal in their reasoning as to why psychiatry was essential. While attention has been drawn to the differences, the common ground and shared beliefs must also be noted. For it was really only the dissidents and a handful of the more 'dissident-eclectics', who appeared at all concerned to change the present structure. Otherwise they all justified the central role of psychiatry and the hegemony of the medical profession.

One eclectic psychiatrist for example, defended the need for psychiatry in global terms

> "Traditionally it has been the sine qua non, but in fact it is essential at some stage in the management of mentally ill patients. It may be to decide upon the diagnosis and treatment, or the legal aspect or upon the management of the patient. Within the hospital it is the essence of the treatment" (1609).

There were others who more specifically talked of the way the

> "Illness per se will have some biological correlates and particularly with schizophrenia, manias and depressions, may be primarily biological, stemming from a disturbance in the central nervous system. In so far as there is physical ill health the patient needs to be treated on the medical model. To talk of the mental illness being a myth, and of it being a social disease caused by disturbed interpersonal relationships is just nonsense. Doctors have to be involved because many mental illnesses are physical in origin being neither environmentally caused nor functional" (1600).

Significantly, while some psychiatrists, such as 1600 above, appeared to consider schizophrenia to be an organic illness, others saw it as being a

functional one, and as one of them observed

> "The psychiatrist has to decide all the time whether he is dealing with an organic or functional disorder, the more the latter, the more other people will be involved. Even so, the overall care of the patient must remain with the doctors as a class, they have been trained for this, and this should not be in the hands of anyone else" (1502).

Like 1506 quoted on p.201, many psychiatrists believed that they were essential because of the use of drugs. One commented "Just think of the effects upon the community if all the psychopaths were running about outside, without any treatment" (1406). Others simply referred to the general utility of the drugs, even when they did not believe they cured the patients. Others located the importance of psychiatry in the act of diagnosis. Many suggested that psychiatrists acquired certain abilities that made them essential not only for the diagnosis but also for deciding upon the treatment.

> "Deciding the diagnosis is the most important thing of all. For this you need someone who is experienced with mentally ill patients. Psychiatry is such an inexact science that each patient has to be treated separately. Most patients need drugs, mental illness is so vast and complicated that there is a need for a doctor to draw together all hands and be the coordinator - to get other people to help you. The initial assessment is the most important thing that we do, we often go wrong, it's a terrible mixture of clinical experience, general knowledge and intuitive judgement" (1603).

This quotation repeats many of the points made by the other psychiatrists, but it also draws attention to the importance that some psychiatrists attached to their 'intuitive judgement', 'all round experience' (1501), 'special understanding' (1519), 'clinical experience' (1602), 'more complete training' (1514), or other special attributes that made them essential (1). Some suggested that the fact of their legal responsibility made them essential, while 1600, went so far as to suggest this made them

(1) As one eclectic said "The psychiatrist sees the whole patient, as a consequence of his broader training. He not only knows about medicine but also psychology and sociology" (1503).

more morally responsible.

> "Neither the psychologists nor social workers have the legal or moral responsibility that we have for our patients. We think only of patients, we don't draw a dichotomy between bodies and minds as we have a responsibility for both".

As noted at the outset and also in the description of the eclectics, some of the psychiatrists were more circumspect in their claims than some of those quoted above. 1604 for example, thought that psychiatry was

> "only essential under present arrangements. No one could manage without using drugs at some time, though I am personally rather shocked at the extent to which they are used in this hospital. In Holland where I come from, there is not the same assumption that the doctor be on top and decide everything, as is the case here".

Several referred to the limitations of physical therapies and one commented that

> "the personality of the psychiatrist is much more important. Not that I am denegrating the standard therapies, ECT and drugs are necessary and useful. But when you use organic therapies, their success, depends on the <u>personality</u> (emphasis added) of the doctor - it has nothing to do with the drugs themselves" (1407).

As noted in the section on the dissidents, they found themselves reluctantly accepting the need for psychiatry on the grounds of there being few alternatives. Thus, while the majority of psychiatrists believed that not only were they necessary, but also essential, there was a minority (9 of the 38) who were more equivocal, and who provide the ground for suggesting that the claimed medical mandate is undermined in some quarters by a few dissenting psychiatrists. This tendency can be further illustrated in the following section.

(1) The way other psychiatrists and other staff stressed the importance of particularistic qualities and attributes will be analysed in Chapter 9.

The justification for medical hegemony

In the section on the dissidents attention was drawn to the criticisms that were expressed of the medical direction. One of the dissident doctors commented that

> "This is not necessary, except that our society is conditioned to authoritarianism, so not only do the doctors want to have complete control - this is what our training has brought us up to believe as our natural right, but also other staff expect to be led" (1511).

Interestingly, a few doctors noted how, as one of them expressed it, "I regard it personally important to be in the lead speciality, if there is to be a leader" (1515). Most of them though, defended the need for medical direction in more general terms of the organisational necessity for leadership "It is vital that there is such direction. It is important that there is a boss, this is something that I feel very strongly about" (1600). Another doctor talked of how

> "The hierarchy is always there, and I don't think it's the aim of the therapeutic community to knock out the hierarchy. I cannot see anything working without a hierarchy, it reduces anxiety. So it's only natural that we have control over those beneath us" (1513).

Other doctors located this need for direction with their legal responsibility "If the medical profession has legal responsibility, then it has to have some directive powers" (1509). However, as the descriptions of the ideological types showed, there were some psychiatrists who were less emphatic about this.

One of the eclectic psychiatrists talked of

> "being a member of the team, without necessarily being the leader. One has a certain amount of formal authority, but the extent to which the doctor is the leader of the team is very much dependent upon what others think of this role. I don't think that hierarchical structures are a good thing or that the doctor should necessarily be the leader, but others often expect you to be the leader ... as it is the psychiatrist is the leader in the community and we are important at keeping the team together and keeping a watchful eye over what is going on" (1608).

As previously noted the suggestion that 'others' expect them to be the leaders, or that the 'others' might even take over was a dominant feature of the voluntarism of the 'eclectic' ideology. As one of the consultants claimed

> "On the whole, the doctor is the person with the greatest all round experience of what is going on. Within the hierarchical structure of the NHS, he has been looked upon as the natural leader. If he is able to do this, he will be the natural leader, if he is not, there will be an inefficient organisation and someone else will take over" (1502) (1).

Significantly, the eclectic psychiatrists talked much more frequently of providing 'guidance' and 'coordination', than 'direction' and 'supervision'. However, this did not mean that they did not believe it only right that they should have these powers. Whereas many 'doctors' asserted that their authority flowed from their concern to treat the physical illness, the eclectics sought justification in their 'greater understanding' or saw it as being forced upon them by the wider society.

The psychiatrists' view of their own expertise

Many references have already been made to the various claims that the psychiatrists were making about their knowledge, skills and expertise. The previous sections within this chapter have touched upon these claims, and they were also outlined in the descriptions of the ideological types. The justification for considering this issue separately stems initially from a need to summarise what has been said elsewhere and also to elaborate

(1) Another talked of "Society demands it, we are legally responsible for the patient, and also the public only accept that they receive treatment from a doctor. I do not feel this way, but it is forced upon us" (1507).

upon a few points that have previously only been mentioned in passing. It is also important to consider the nature of the claims being made by the psychiatrists to possess certain expertise, so thatthese claims can be set against the view of the psychiatrists held by the lay staff. Such a comparison will be carried out in Chapter 9.

Table 15. The psychiatrists' views of their own expertise - as shown by the number of times certain activities were mentioned

	Woodlands	Ashbury	Oakdene	Totals	%
Medical Activities (Exclusive view)					
Medical tasks only	4	3	3	10	26.3
Diagnosis	2	5	4	11	28.9
Physical treatments	12	6	4	22	57.9
General medical care	3	2	5	10	26.3
"Treatment"	18	6	3	27	71.0
Inclusive View and Other Tasks					
Psychotherapy	9	4	-	13	34.2
Expert in interpersonal relationships	2	1	2	5	13.2
Admission of patients	3	-	1	4	10.5
Social control	2	-	1	3	7.9
Overall understanding	2	2	1	5	13.2
Being a 'doctor'	1	2	1	4	10.5
Leadership/direction	4	5	3	12	31.6
Coordination	8	4	2	36 (94.7) 14	36.8
Guidance	6	3	1	10	26.3
'Being responsible'	5	2	4	11	28.9

Table 15: (cont)

	Woodlands	Ashbury	Oakdene	Totals	%
Management	2	2	1	5	13.2
Policy making	2	1	-	3	7.9
Total number of psychiatrists in setting	21	10	7		

The qualifications that were made earlier on (in Chapter 1) about the role of such tables in this study should be borne in mind. This table and similar ones are merely for illustrative purposes so as to give an overview of the range of activities that were mentioned. Several staff referred to the same activities more than once, though in different ways, and thus the figures for certain activities are inflated. However, the value of adding the number of mentions in this way can be shown when a comparison is made between the psychiatrists' views of their expertise and the lay staffs' views of the psychiatrists in the next chapter.

The point that many psychiatrists, especially those who have been termed the doctors, located their expertise primarily and almost exclusively with their medical knowledge need hardly be made again. Such psychiatrists tended to stress how their work as psychiatrists, was no different to that of any doctor. Thus, the diagnosis, the supervision of the treatment and the decision to admit or discharge patients were all considered to the tasks of the psychiatrist. Other such doctors 'limited' their expertise to giving physical treatments. Some justified this by stressing the "need for pharmacological therapies with the psychosis, no one else can give them, but it doesn't matter who treats the neurotics" (1509). There were also some of the more "dissident" eclectics as well as the actual dissidents,

who thought the only unique expertise that the psychiatrists possessed was that of administering physical treatments. They took a utilitarian view of such treatments, by stressing their limited effectiveness. Some other psychiatrists also noted the importance of their general medical knowledge. Such psychiatrists were often working either on the geriatric wards or within Oakdene, where it might be expected that physical problems were more evident than in other settings. Although most psychiatrists made reference to their general medical work, it was only a minority who wished to locate their expertise solely in that area. Instead the majority took a much more inclusive view and mentioned how they also acted as 'therapists', 'psychotherapists', 'coordinators', 'leaders of the team', 'administrators', 'teachers', 'researchers', 'members of the team' and 'culture carriers'. For example

> "My role is not only treating the patient, but also acting as a medical administrator. Further, I coordinate the team and am responsible for the patient. I work mostly as a coordinator, but I am also a consultant in the sense of being an adviser and teacher to the rest of the team. When dealing with out-patients, I am much more individually involved. I tend to do my own diagnostic work and refer people on for psychotherapy. I sometimes take on patients for psychotherapy myself and I have also been supervising the psychotherapy that my junior doctors do" (1600).

Another talked of

> "Looking after the patients, seeing new admissions, examining their life situations, their past and future situations, seeing patients on the acute and admission wards, as well as on the long stay wards. I try to get the patients to work within the hospital and after they leave the hospital. My job is specifically to coordinate the unit and to keep an eye on what's going on" (1603)

While another psychiatrist in the same hospital who himself talked of being "more of an administrator than a psychiatrist", pointed out how his primary task was being a

> "Team energizer, which means basically coordinating the efforts of all the other staff, while at the same time trying to decide on a policy for each team and ward. This should be done through discussions and persuasion, but at the same time the consultant has a responsibility to formulate a general policy for the hospital and the catchment area" (1602).

He went on to talk about his wish to establish a register of patients like the one in Camberwell, and of his desire tocarry out some research into "the effectiveness of social work and how far we are deploying our resources efficiently". Many of the consultant psychiatrists observed how they spent more time doing administration than anything else.

A few of the more senior psychiatrists mentioned their teaching or tutoring role with the junior doctors, and some generalised this to include all the staff. Some of the consultants had reputations for being didectic in their ward rounds, and many indicated how they thought it was part of their job to give advice to junior staff (1). Regarding the other academic task of carrying out research, remarkably few referred to this as being one of their central activities (2). Although there were some who mentioned it, such as 1602 above, or 1505 who referred to his work for an MD thesis or 1406 who referred to her neurological research.

Other psychiatrists attached particular importance to certain activities such as deciding on admissions. This was seen as an activity that only the psychiatrist could carry out by 1402, whereas others noted how it was they that decided on admissions, because current administrative practices only allowed for the payment of consultants for domicillary visits. Several of the more eclectic psychiatrists noted how they "would not object to other staff taking part in this if it could be arranged", as 1501 noted. Many psychiatrists referred to how they carried out psychotherapy, and

(1) 1607 for example, considered it was part of his job to act as a therapist for the other staff, as well as for the patients.

(2) This confirms the picture presented in the recent report on the research being, or rather not being, carried out by psychiatrists (Russell and Walton, 1970).

clearly many thought they were competent to not only decide whether a patient needed it or not, but also to carry it out themselves if necessary. Interestingly, though, no psychiatrist wished to be thought of as only a psychotherapist, although a few had undergone training in psychotherapy (1). As noted in the analysis of the eclectic ideology, it was the eclectics who were more likely to make reference to carrying out psychotherapy.

Frequent reference has already been made to the way the eclectic psychiatrists attached considerable importance to their leadership role or as 1501 expressed it

> "I have an overall function relating to the admissions ward that I would see as a sort of guidance role, to see that the staff are balanced, and that the team is not consultant dominated or too medically orientated. One cannot escape from a good deal of responsibility without guiding the unit, but one must be careful not to become an authority figure".

The contrast between this view of leadership, and the doctors concern to give 'direction' has already been noted. It is significant that 'leadership', 'coordination', 'direction', 'guidance' and so on were mentioned far more frequently by the eclectics as being essential tasks than was 'treatment', which might have been considered to be the natural prerogative of the psychiatrists. That so much attention was directed towards this activity, suggests a concern to legitimise their claimed mandate among those who might note the absence of means. For while some psychiatrists claimed they possessed certain means of treatment that were uniquely theirs, there were others who devalued such 'treatments', by suggesting that real 'therapy' lay elsewhere.

Psychiatrists can thus be seen to be making various claims to have

(1) 1518 indicated, that in other circumstances, she would practice only dynamic psychotherapy. 1512 and 1607 were both undergoing analysis and intended to practice as psychotherapists. 1507, acted as consultant psychotherapist for the staff at the Woodlands, and supervised the group psychotherapy within the Day Hospital. This is explored in more detail in Chapter 9.

both 'technical' knowledge, such as over the administration of physical treatments and the investigation of organic conditions that might be causing the psychiatric symptoms. However, even these activities according to the psychiatrists themselves, require 'intuition' and 'practical experience' and are only a part of their work.. The many other activities that psychiatrists carry out apparently requiring even more 'indeterminate' knowledge and abilities. Having examined the claims being made by the psychiatrists for themselves, it is appropriate to examine the nature of the recognition they grant the lay staff. The structurally dominant position of the medical profession means that the psychiatrists can, to a large extent, decide how far the social workers and psychologists can fulfil their own claimed mandates. The psychiatrists are the key audience for the lay staff and more than any other occupation can either grant or withold 'professional' recognition (1).

The psychiatrists' views of the lay staff

This section on the psychiatrists' views of the lay staff should be regarded as an extension of, and almost an application of the medical mandate. Further, accepting that the psychiatrists are able to decide whether or not the lay staff can have access to their patients, it is important to establish openess or restrictiveness of the former towards

(1) Goode (1962) has drawn attention to the importance of role of key audiences as 'that legitimise an occupations claim to be a profession, while Olesen and Whitaker (1968) have pointed out how, at an individual level, trainee nurses seek legitimation for their ability from other staff. Likewise Rushings (1964) noted how social workers, in particular looked to the psychiatrists for confirmation of their claims to be professional.

the latter. Further on this question will be approached from the point of view of the lay staff.

In Chapter 5 attention was drawn to the uneven distribution of staff within the treatment settings that were studied. This meant that many psychiatrists rarely came into direct contact with the psychologists, although nearly all of them worked with social workers, and came into almost daily contact with them. Thus, while some psychiatrists observed how they 'never see the psychologists' or 'had very little contact with them', most of them noted their close working contact with the social workers. Significantly, there were no references to there being a 'problem' about the social workers, whereas several psychiatrists, especially those within Oakdene, the subnormality hospital, made constant reference to the 'problem of the psychologists'. The general acceptibility and acceptance of the social workers was illustrated by the frequent references, even from the most organically orientated, to how 'essential they were' and how 'I could not manage without one' (1603).

As Tables 16 and 17 demonstrate, the psychiatrists mentioned a much wider range of tasks for the social workers to perform, than for the psychologists. Indeed, a few psychiatrists mentioned how they 'did not know' what psychologists did, whereas nearly all of them mentioned several tasks that the social workers might do. Overall, there were some 75 references to what might be termed the 'welfare tasks' of the social workers. Broken down, this included 28 references to specific administrative of welfare tasks, 22 to 'information gathering' or 'interviewing relatives', 12 to 'follow up', 10 to 'providing support', and 3 to dealing with 'social matters'. There were also some 23 references to social workers being 'therapists', this included 9 references to being 'involved on the wards', 8 to carrying out psychotherapy with the family or casework with the family, and 6 references to being a therapist with the patient.

Table 16: The psychiatrists' views on the social workers' tasks (number of mentions)

	Woodlands	Ashbury	Oakdene	Totals
WELFARE				
Welfare/admin.	12	9	7*	28
Information/interviewing relatives	12	6	4	22
Follow up	7	2	3	12
Support	5	2	3+	10
Social factors	2	1	0	3
Totals	38	20	17	75
THERAPY				
Involved on wards	7	2	0	9
Therapist with patient	3	3	0	6
Psychotherapy or casework with family	5	2	1	8
Totals	15	7	1	23

* references all to rehabilitation

\+ references all to supporting family

Table 17: The psychiatrists' views of the psychologists' tasks (number of mentions)

	Woodlands	Ashbury	Oakdene	Totals
Testing	16	10	5	31
Research	9	1	3	13
Members of the team	4	1	0	5
Behaviour therapy	2	4	1	7
Psychotherapy	2	3	1	6
Therapy	2	0	0	2
Stimulus/advice	2	2	0	4
Vocational guidance	1	0	1	2
Nothing	0	0	2	2

Regarding the psychologists, there were 31 references to their 'testing, assessment and diagnostic work'. Next came 'research' with 13 references. This was followed by 'therapy' that received 10 mentions (4 for behaviour therapy, 4 for psychotherapy and 2 for just therapy). There were 5 mentions of being 'members of the team' and 4 of providing 'stimulus and advice', 2 said nothing at all, and 2 mentioned vocational guidance. Significantly, there were no references at all to the teaching role of the psychologists. This is surprising, because most junior doctors receive tuition in psychology from the clinical psychologists, for their Diploma in Psychological Medicine examinations. Thus, the psychologists were recognised for a more restricted and limited range of tasks than the social workers. This may have reflected the way the psychologists at the Woodlands in particular, lacked the opportunities to 'role create' in the way that the social workers could. However, this limited recognition found expression in other ways and suggested a general reluctance to see the psychologists as anything other than auxilliaries, 'technicians', or as 'path. lab. assistants'. Frequent analogies were drawn between referring a patient to the psychologists for an IQ score and referring the patient for an EEG or some other tests. Of the 38 psychiatrists, 20 thought the psychologists had an auxilliary relationship towards themselves, 3 thought there was no relationship at all, while 15 thought it was a complementary one (1).

(1) Many of these also made comments that indicated how they thought of psychologists as being 'technical assistants', to whom patients were referred, while they interpreted the results from them.

Table 18: The psychiatrists' views of their relationship with the social workers and the psychologists

	Woodlands		Ashbury		Oakdene		Totals			
	SW	Cp	SW	Cp	SW	Cp	SW	%	Cp	%
Complementary	17	9	9	4	3	2	29	(76.3)	15	(39.5)
Auxilliary	4	12	1	5	4	3	9	(23.7)	20	(52.6)
No relationship	-	-	-	1	-	2	-		3	(7.9)
Totals	21		10		7		38	(100%)		

Table 19: The psychiatrists' view of how far the social workers and psychologists were essential for the treatment of mental illness

	Woodlands		Ashbury		Oakdene		Totals			
	SW	Cp	SW	Cp	SW	Cp	SW	%	Cp	%
Yes, with few qualifications	15	6	7	1	3	2	25	(65.8)	9	(23.7)
Equivocal, many qualifications	4	10	2	4	4	1	10	(26.3)	20	(52.6)
Not at all	-	1	-	4	-	4	-	-	9	(23.7)
Don't know	2	4	1	1	-	-	3	(7.9)	5	(13.2)
Totals	21		10		7		38	(100%)		

In contrast, the social workers were more often regarded as having a complementary relationship. Twenty nine psychiatrists thought this to be the case, while 9 considered them to be auxilliary. The greater importance attached to social work can further be illustrated by reference to Table 19 that shows that 27 of the psychiatrists considered social work to be essential (even if some of these expressed minor qualifications), while 10 were more equivocal in so far as they expressed major qualifications. When asked about the psychologists, only 9 psychiatrists

considered them to be essential, 15 gave very mixed and equivocal responses that severely qualified the importance they attached to psychology, while 9 declared that it was not all essential, and 5 said they did not know. That many psychologists were aware of the low esteem that the psychiatrists held them in, was apparent from the many comments that they made about being 'merely auxilliaries'. The difference in the evaulations of the psychologists and social workers appears rather surprising, that is, until the particular value attached to social work is examined.

In the previous chapter, attention was drawn to the way the doctors in particular placed considerable value on the 'welfare tasks' of the social workers. Under this heading were included such activities as taking social histories, contacting relatives, arranging accommodation, putting the patient in touch with various statutory agencies and in general, administering various welfare benefits and being supportive to patients and their families. However, although a wide range of tasks was mentioned, these were nearly always ones that were supplementary to the treatment that was being given by the psychiatrists, rather than being central to the treatment itself. For example, many psychiatrists mentioned how valuable the information that social workers gathered from relatives was in 'completing the picture', but at the same time they stressed how only they could evaluate the relevance of this information. Significantly many valued this information collecting, for what amounted to surveillance reasons. As one 'doctor' observed

> "Social histories are very, very important, absolutely so. Many relatives won't talk to the doctors very readily as they think we are only concerned with the patient's interests. Whereas the social worker is seen as being more neutral, and so they may be more frank with them in saying just what the patient has been doing to them" (1605).

This doctor went on to stress how much she valued the comments of social workers, and how as a junior doctor she felt more in common with the social workers than she did with her own seniors. Even so she noted that

> "I don't expect them to make decisions about the treatment, nor should they have this responsibility, although they can always comment and this we should welcome."

Social workers were also particularly valued by psychiatrists working in contexts, where the presenting problems were primarily of a welfare nature. This was especially the case on the geriatric wards and also at Oakdene. At Woodlands in particular, reference was made by all the 6 psychiatrists on the geriatric wards to the particular importance of the social workers in finding Part 3 accommodation for patients, or else making arrangements for relatives to look after the discharged patient. The informal contacts that the social workers had developed with the matrons of old people's homes, and their general knowledge of the available facilities made them indispensible to the efficient running of the units. As one of the consultants on the geriatric unit at the Woodlands observed

> "We are dependent upon the social workers in many ways. Initially they obtain a social history from the relatives or neighbours. This is essential as the patients are often unable to tell us anything about themselves. They can later use their contacts and knowledge to find accommodation prior to discharge. So often, discharge is dependent on the social circumstances of the patient, that we can do nothing without the social workers help" (1504).

Similarly, within Oakdene the social workers were particularly valued for their ability to find shelter, accommodation and work for the 'higher grade subnormals' who could live outside the hospital. Mention was also made of the importance of offering support for the relatives of the handicapped child.

In the analysis of the social workers view of their own expertise, it will be noted that many felt that they had a special understanding of the family. This appeared to have received some recognition from the psychiatrists, although most of them appeared to conceive 'involvement with the family' to mean 'gaining information from the relatives', or 'letting them know what we are doing to the patient', or 'telling the relatives how ill the patient is', or offering 'support', 'comfort' and sometimes more material forms of assistance. Significantly, there were hardly any

references to the social workers understanding more about the family, or any suggestions that they might engage in family therapy. One 'doctor' even asserted that

> "The social workers only sees the management problem, whereas the doctor is responsible for the patient's well being, career, person and to the patient's family. The social workers often give too much importance to the patient and not enough to the family. Social workers can help with the social problems, but not with the therapy. unless they have had a basic training in psychiatry they can do more harm than good" (1517).

In this way this particular doctor detracted from the idea of social workers having any special understanding or responsibility for the family. Others did likewise by stressing the importance of the practical assistance that the social workers should be providing for the relatives. As 1515 expressed it

> "What they should let us know, is what is going on at home and at work, where we don't see the patient. This information helps us to make the decisions about the patient. After the discharge, they can follow up and again let us know what is going on, and also give common sense advice and practical assistance".

As noted in the analysis of the 'eclectic' ideology, one feature of it was the greater willingness to accept that lay staff should also act as 'therapists'. As 1512 noted

> "A very important task of the social worker is not only to see the relatives of the patient, but also to act as psychotherapist and co-therapist with the groups. They should be involved upon the wards and be forming relationships with the patients while in hospital to be continued once the patient leaves the hospital".

However, as noted in the analysis of the eclectic ideology, such psychiatrists rarely suggest that the social workers or any other members of staff have any special abilities as therapists, because a tenet of their ideology is the belief that

> "In the actual treatment situation, the role is interchangeable, anyone on the staff could support the patient, or give supportive psychotherapy" (1607).

There were also some critics of the social workers for engaging in psychotherapy. As one consultant observed "The trouble is that too many social workers dislike the practical side of their work, and would rather be doing

minor psychotherapy" (1602).

Many other quotations could have been given to illustrate the way that on the one hand, the social workers were accepted as being essential, while on the other they were not looked upon as 'professionals' to whom the psychiatrists turned to for advice or for a special understanding in anything other than those activities that many social workers were seeking to divest from themselves. In other words, the social workers were considered functionally indispensible, because of their access to various welfare resources, hostel accommodation, and their ability to collect information from relatives and employers on the patient. As one 'doctor' observed "If I didn't have a social worker then I would have to do the job myself" (1601) or as another pointed out "If you get a social worker not doing her job properly, then the whole thing falls down" (1603). Significantly, no one made any similar comments about the psychologists, thereby illustrating the lack of immediate relevance of their contribution for the average psychiatrist.

Attention has already been drawn to the way most psychiatrists merely expected the psychologists to provide them with additional information on patients. That most psychiatrists saw this as an auxilliary service, to be requested when they thought it was necessary, was apparent throughout the interviews. To give one example that was typical of many

> "Purely as psychologists they have the technical expertise of their measurement function - this is of limited though some value in our clinical work. They round off what we can obtain from the clinical situation, but at the same time it is possible to do good psychiatric work without the contribution of clinical psychology, as their measuring instruments are less accurate than the pathologists. So they are auxilliary, they provide measurement where necessary, but the ultimate use of this must rest in the hands of the doctor. The situation is exactly comparable with that of the physician in a general hospital. A psychologist might suggest that there is an organic factor, and one would consider their findings in the light of ones other knowledge. But the decision to treat must always remain with the doctor" (1502).

This same psychiatrist also suggested that they could 'participate in the

therapeutic community like any other member of staff if they wished', but another who gave a very similar account to the above commented that

> "The psychologists can also contribute within the community with his own particular gifts. He can do psychotherapy, but there is no particular need for psychotherapy to be done by the psychologists, as any member of staff with the appropriate talent can carry it out" (1501)

Thus, once again, the psychiatrists can be seen as detracting from any claims that the lay staff may make to be specialist in non-medical forms of therapy, by suggesting that no special training is necessary. Further than that, some psychiatrists appeared to only value a **psychologists** contribution for particularistic reasons. An example of this being provided by 1505,

> "Their contribution is limited in psychiatric practice. Maybe it's because they have been trained wrongly, or maybe it's because we approach things from different angles ... I have known other hospitals where the psychologist was very involved with what went on on the admission unit. She could contribute by providing a slightly different approach. But this is a personality thing, for their training as psychologists doesn't appear to have much relevance for practising psychiatry" (1505).

Within this quotation, there is a contradiction of, on the one hand valuing the 'different approach' of the psychologist, and on the other of attributing their lack of 'clinical relevance' to having precisely a 'different angle'. This contradiction is resolved by seeing it all in terms of personality, thereby negating any 'professional' contribution of the clinical psychologist. That it should be the psychiatrist who should decide the relevance of the others contribution is an assumption that nearly all the psychiatrists shared, irrespective of whether they were eclectics or doctors. The above psychiatrist was not alone in relating the psychologists relevance to their personality for many made similar, if less direct references to 'it depends on the individual' or some other verbal formula meaning the same thing.

At Oakdene, for example, almost everyone made some reference to the personalities of other staff as being a contributory factor to the 'trouble'

there was between the psychiatrists and the psychologists (1). The consultant at the centre of the trouble indeed stated that

> "The difficulties here are due to personality problems. I am so accustomed to dealing with people that I respect that you never asked who interpreted what, as you had worked with them for so long. Here I find the psychologists are just not of the same calibre as the ones that I have worked with before" (1402).

He himself, while warning against attempting to restrict the psychologists to just testing IQ's, had clear ideas as to what he thought they ought to be doing. Instead of being involved in the actual running of the Activity Centre, he wanted them to carry out research into its effectiveness and to develop further instruments for measuring the progress of the children.

Another doctor at the centre of the trouble at Oakdene thought that

> "one of the reasons why there is so much friction here between the psychologists and psychiatrists is that it is so difficult to define just what the psychologists should be doing. They have been trained for testing in certain areas and they are attempting to develop their own techniques, but are feeling very threatened as they are attempting to use techniques that are not valid in the field of subnormality. So they are taking on a variety of other roles, such as counselling, medical and social work" (1407).

Several other comments were forthcoming about the psychologists feeling 'threatened'. 1400, for example, thought that

> "Their area of competence is being increasingly whittled away by the contributions of the medical staff, and newcomers such as the ethologists. They are in a crisis regarding their role in all hospitals, and in particular in subnormality ones".

What is interesting about the situation at Oakdene was the open and declared conflict between the psychiatrists and the psychologists. The psychologists had expanded their role to include a range of activities that the doctors considered to be outside their sphere of competence. In an effort to contain the psychologists, the psychiatrists were attempting to re-impose a more traditional relationship upon the psychologists by suggesting that

(1) See p.321 for further details of the Activity Centre.

"they concentrate more on research and the development of their measurement function" (1400). In a very real and obvious way the medical profession was seeking to assert its control over an 'ancillary occupation'.

The situation at Oakdene highlighted issues that were not apparent at either the Ashbury or the Woodlands, because the involvement of the psychologists in matters affecting the psychiatrists was less direct and immediate. Certainly, some of the psychologists were seeing patients for therapy, but none were involved in activities that the medical profession wished to bring under their control. In many ways the remarkable feature of Woodlands in this respect, was the very consensus and compatibility between the psychologists and the psychiatrists in their expectations of one another. Some denigrating comments were made, but overall there was little concern expressed about the psychologists. Indeed, some of the junior doctors expressed a wish to see more of the psychologists, and a few noted how they were discouraged from referring patients to the psychologists by their consultants. As 1518 observed "You have to accept your consultant's opinion, and mine does not approve of personality or other psychological tests" (1). As might be expected, many of the eclectic psychiatrists expressed liberal and open attitudes towards the psychologists in not wishing to restrict them to certain activities. The significance of

(1) Interestingly, this same psychiatrist, who had worked in both Turkey and the United States commented that "In the States, the doctors, the social workers and the psychologists are all treating the patient and there is role confusion and fights between them. But in this country there appears to be clearer role differentiation. Though I am sure there is role confusion, though not so much for the doctors. The conflict is not so openly expressed here as it is in the US". Several other psychiatrists who had worked in other countries made somewhat similar remarks, and those that came from Australia or New Zealand seemed more prepared to accept the psychologists as skilled psychotherapists.

such beliefs that were expressed in the abstract, being the creation of an atmosphere of tolerance and freedom, even if the reality was somewhat different.

Conclusions

To summarise this section on the attitudes of the psychiatrists towards the lay staff, it has provided further evidence on the nature of the claimed medical mandate, and in particular the assumption held by eclectics and doctors alike that only they can decide on the relevance of the information or the services provided by the social workers and the psychologists. Even when the lay staff were granted recognition of their importance, their value was always judged in terms of its relevance for the psychiatrists' perception of the patient's needs. Significantly, the social workers were more readily accepted and regarded as more essential than the psychologists. This may have been partly because of the importance of providing social work assistance to get patients out of hospital, but also it may have reflected the way most social workers appeared to have accepted their place within the psychiatric teams, and to be working in a way that the psychiatrists approved. Some criticisms were levelled at the social workers, especially by some doctors who did not approve of them 'wasting their time' by engaging in therapy, but overall, most psychiatrists found fewer faults with them than they did with the psychologists. It might be thought that the general acceptance of the lay staff shown by the medical profession indicates how the former have been recognised as professionals in their own right. However, apart from the recognition that both social workers and psychologists possess certain technical competences or abilities, there was an overall reluctance to grant them any recognition that they

possessed any theoretical or general understanding that was superior to that of the doctors. If the psychologists contribution was not dismissed as being 'irrelevant to clinical practice', then it was detracted from by suggesting it was the individual psychologist who was of value, not his disciplines knowledge or techniques. Similarly, with both lay staff, where they were recognised as being 'therapists', they were set alongside all the other staff, including the psychiatrists, who were also 'therapists'. Certainly, a few psychiatrists thought some of the lay staff were more skilled at psychotherapy than they were, but they reserved the right to judge which lay staff possessed such superior skills. These issues will be explored in more detail further on. In particular, in Chapter 9 attention will be directed towards the dilemmas facing the lay staff when they seek to divest themselves of those activities, for which they are recognised, but which at the same time continue to define them as auxilliaries in their relationship with the medical profession.

The way in which the psychiatrists seek to define the contribution of the lay staff as less essential and subordinate to their own, can thus be seen to flow from the assumptions that underline the claimed medical mandate. This mandate gives expression to not only claims about the superior skills and knowledge of psychiatrists, that are considered to be of both a technical nature and so indeterminate as to reside in the personality of the therapist, but also to assertions about the structure of the relationships between the various occupations. Clearly, as the previous chapter demonstrated, and as this one has illustrated, the psychiatrists do not display a united front over the details, even if they agree over the essentials. Such contrasts mean that the lay staff have differing experiences of the psychiatrists and thus do not share the same opinions of the psychiatrists abilities, or of the latter's expectations of themselves. In subsequent chapters these questions will be explored from the point of view

of the lay staff. The psychiatrists may be in a sufficiently strong institutional position not to feel any immediate challenge from the lay occupations, but as Goffman (1968) has pointed out

> The professional psychiatric staff itself does not have an easy role. The members' medical licence gives them one of the firmest claims to deference and regard available in our society, and one of the firmest service expert service occupations, yet in the mental hospital their whole role is constantly in question. Everything that goes on in the hospital must be legitimated by assimilating it or translating it to fit into a medical - service frame of reference. (p.334)

CHAPTER 8

MENTAL ILLNESS AS 'MORE' THAN A MEDICAL PROBLEM AND THE LAY STAFF'S VIEWS OF THE PSYCHIATRISTS' EXPERTISE

Summary: This chapter contains what may be regarded as the lay staff's reply to the medical mandate being claimed by the psychiatrists. In particular, attention is directed to the various ways, by which the lay staff come to terms with the pervasive nature of the medical profession's role and authority. For this reason it is necessary to examine the importance the lay staff attach to psychiatric methods of treatment, and also how far they consider the treatment of mental illness to be a medical problem. In this context material is presented on the lay staff's regard for the psychiatrists' expertise, as this indicates how far they have legitimised the latter's claims to be the profession for treating mental illness. The aim of this chapter is to provide further evidence on the way the lay staff accommodate themselves to the medical profession's dominance, even when they are critical of it.

Introduction

The previous chapter attempted to illustrate the pervasive nature of the mandate being claimed by the psychiatrists, and further to point to the way in which nearly all psychiatrists seek to subordinate and devalue the contribution of non-medical staff, to that being made by themselves. It was suggested that while some psychiatrists defend their current dominant position by referring to certain technical skills, the majority rest their claims on indeterminate and personalised abilities. If the dominance of the

medical profession is held to be problematic, for heuristic if no other reason, then a relevant question to ask, is how do the social workers and psychologists view the claims that make up the medical mandate? For they are the two most important 'audiences' of the psychiatrists and as Hughes (1958) has pointed out "When the presumption of a group to a broad mandate ... is explicitly or implicitly granted as legitimate, a profession has come into being" (p.79). This chapter is therefore concerned with examining the extent to which the lay staff either explicitly or implicitly legitimise the claims being made by the psychiatrists.

This problem will be approached through a detailed examination of the social workers' and psychologists' beliefs about the need for 'mental illness' to be a medical problem, and the importance they attach to psychiatry for the treatment of mental illness. A further and important element in this question being the lay staff's attitudes towards the use of physical methods of treatment, over which they obviously have no direct control. As the primary focus of this study is the mental hospital context, then the importance attached to physical treatments will be given particular attention, in view of the consequence that their usage has upon the social structure of these institutions. In other words, it is being suggested that staff relationships are structured and affected by the technology of the treatment processes. Clearly, if no physical treatments whatsoever are being used, then it might be supposed that psychiatrists would not be in the same position over other staff, as they are when nearly all patients are receiving some form of medication. As it was, nearly all the staff interviewed during this study were working in contexts where the majority of patients were receiving medication of one sort or another.

As already noted, social workers and clinical psychologists can be regarded as being the most important audiences of the psychiatrists, even though they are by no means the only ones. They are, however, the staff in

the best position to challenge the methods and practices of the psychiatrists, if they should wish to do so. Starting from the assumption that these occupations might be expected to be 'challenging' the psychiatrists, so as to further their own claims, the more interesting and relevant question becomes that of explaining why many psychologists and social workers either appear to make no challenge whatsoever to the psychiatrists, or if they do, then it is only made in very moderate and accommodating terms. In the analysis of the ideologies in Chapter 6, evidence was provided of the generally accommodative approach taken to the psychiatrists. The aim of this chapter is to elaborate on and draw out the various ways in which this accommodation comes about.

It is unfortunate that at certain points in this chapter, as in the others, there will be some repetition of points that have already been made in the analysis of the ideologies. This is because of the need to approach the questions under consideration from the perspective of the lay staff in general, as well as from the particular angle of the sub groups within these occupations. In the chapter on the ideologies, the aim was to illustrate how groupings of staff 'defined their situations' quite differently from one another. The intention of this, and subsequent chapters, is to examine the common features of the dilemmas facing lay staff working largely in medical contexts. Such dilemmas it is believed serve to illustrate some of the themes of this study, such as the nature of the autonomy granted to lay staff, the pervasive nature of the medical mandate, and the nature of the consensus and conflict within British psychiatry. In other words, it is believed that the way in which the lay staff reconcile themselves to and justify their own situations, provides insights and sources from which to explain the continuing institutional dominance of the medical profession.

Mental illness as more than a medical problem

Table [illegible] shows how the majority of psychologists and social workers do not wish to commit occupational suicide by suggesting that mental illness only be regarded as an exclusively medical problem. One or two of the welfare workers did, however, come quite close to doing so, but this must be related to their limited conception of their own role. One such local authority welfare worker commented that

> "Yes, in fact one of the things that I deplore is the attempt by social work departments to take over from the hospitals. It is a medical problem and we must make no attempt to take it out of medical hands. This is especially the case during the acute phase of the illness" (3511)

In fact very few social workers or psychologists appeared to wish to take mental illness in its entirety out of the hands of the psychiatrists. It is significant that among the social workers, it was in the local authority that most of those saying 'no' were found, as Table 20a shows. Although there were a few comments such as that from 2802, who, after saying "It is not a medical problem, it has no analogy with physical illness", then pointed to the problem of "who else would be better at dealing with these people", but then suggested that if hospitals were run by social workers or psychologists the "it would all be different". What must be here borne in mind was the way that some welfare workers and testers in fact defined themselves out of the treatment, and in this sense were in effect seeing mental illness as a medical problem. As 2700 pointed out

> "I leave the treatment and overall direction of what is going on to the doctors, this is not my concern and it's not my intention to make it so".

This point was illustrated in the analysis of the 'welfare worker' mode of response, and need not be dwelt upon any further. One final quote can be given to illustrate the way their reasoning was almost the same as that of some 'doctors'

"It is, because you cannot divorce mental illness from the medical situation and the physical organism. The mind and body belong to one - you cannot divorce them from one another" (3508).

Table 20a: 'Mental illness as a medical problem'

Setting	Yes(1)		Equivocal		No	
	SW	Cp	SW	Cp	SW	Cp
Woodlands	1	0	11	4	2	2
Ashbury	2	1	4	1	2	0
Oakdene (2)	2	0	0	2	0	2
Local authority	3	-	6	-	5	-
Wheatbury	-	0	-	7	-	1
Willows	-	0	-	4	-	1
Cedar House	-	1	-	0	-	0
Beech Lodge	-	0	-	1	-	0
Totals	8 (21.1%)	2 (5.3%)	21 (55.2%)	19 (70.3%)	9 (33.3%)	6 (22.2%)
Totals of SW and Cp together	10 (13.2%)		40 (62.7%)		15 (27.7%)	

Table 20b: 'Psychiatry as essential for the treatment of mental illness'

Setting	Yes(1)		Equivocal		No	
	SW	Cp	SW	Cp	SW	Cp
Woodlands	6	3	6	3	2	0
Ashbury	3	1	5	1	0	0
Oakdene (2)	2	0	0	2	0	2
Local authority	4	-	6	-	4	-
Wheatbury	-	1	-	5	-	2
Willows	-	8	-	3	-	2
Cedar House	-	1	-	0	-	0
Beech Lodge	-	1	-	0	-	0
Totals	15 (39.5%)	7 (25.9%)	17 (44.7%)	14 (51.9%)	6 (15.8%)	6 (22.2%)
Totals of SW and Cp together	22 (32.7%)		31 (48.3%)		12 (19.0%)	

The largest category of response was those social workers and psychologists who gave very mixed "it is and it isn't" responses and in that sense can be regarded as equivocal. As noted previously, many therapists and professionals gave such responses. Some of these also reasoned in a way that was similar to some psychiatrists, especially those 'eclectic' psychiatrists who wished to appear liberal and non restrictive, while at

(1) In both tables, some of those included in the 'yes' column, might have expressed some qualifications about not seeing mental illness as a 'wholly medical problem' or of psychiatry 'not being absolutely essential'. However, the qualifications they expressed were of a minor nature compared with those who were considered to be more equivocal.

(2) In both tables, the questions were directed more towards the question of subnormality than mental illness, for the staff at Oakdene.

the same time asserting how some conditions must be seen as medical problems. One of the principal psychologists gave such a response.

> "Some are definitely psychiatric problems which need the application of the medical model and some psychological problems also need psychiatric aid, there's a whole range. The extreme of the psychiatric range being where there is a clear organic illness such as senile dementia. This also includes the acute admissions which are also psychiatric problems because they are so acutely disturbed. They need drugs to help themselves and the nurses and they also need to be under section for their own protection - this is and should be the psychiatrists job. All the others from the psychosomatic to the anxiety stages or depressions need not necessarily come under the jurisdiction of the doctor at all. But it should be clear that there is a medical person to evaluate the physical side. This is where a clash may arise over say putting a patient under a section for say depression. It will help when psychologists are registered as we will then be able to deal with a wider range more easily" (2800).

This quotation has been given in full as it contains within it many of the points that similar psychologists and social workers used to reconcile the dilemma that many of them found themselves in. Some mentioned how it had to be a medical problem because as 3601 put it

> "there has to be medical checks on the person's physical condition as malnutrition, drug taking, alcoholism and so on can cause symptoms such as hallucinations and delusions",

or as 2505 stated "You cannot get away from it, you do need drugs to make people controllable. It's unrealistic to allow uncontrollable psychotics to do whatever they like". A few considered that physical treatments were necessary even though

> "Using drugs reflects failure, but you cannot be successful all the time and you get into an awful lot of trouble and difficulty if you do not use them occasionally" (2801.

Several mentioned how they had 'reluctantly' come round to seeing a need for doctors, to give ECT with certain types of depression. Others who declared that it should not be exclusively a medical problem, thought it was better that

> "it should be regarded as an illness, although I accept what Laing et al say about society having caused it. I think it's easier for

relatives, friends and the patient to regard it as an illness" (1) (3605)

Several mentioned how there was a problem of what alternatives there were, as 2902 reasoned

> "Psychiatrists are essential because they are the people that distressed and broken down people are referred to. So what they have to offer becomes essential as society cannot generate the necessary support, insight, and care, etc. for psychotic patients - other methods are too expensive".

For others (such as 2901 and 2903) the problem revolved around

> "who else is adequately prepared to take on this responsibility in our society. I do not think that psychologists or social workers are trained, experienced or whatever to do this. It takes a pretty radical preparing in attitudes and training by the relevant professions and the general public to see them differently" (2901).

Finally the dilemma that many found themselves to be in can be illustrated by the comments of 3606

> "I don't know, two years ago I would have said no - but I just don't know. I am sure that the majority of the people that we have in as patients, one should not regard as being a medical problem in the way that physical illnesses are. Some do have a physical base - though re schizophrenia, I just don't know - I am inclined to think it's not medical as opposed to psychological. There may be different sorts of schizophrenia - some may be physically based. On the one hand I believe that mental illness is an 'illness', but on the other I do not take the view that it is illness that you want to cure. Instead I see it as a process that you can draw from and live with and through".

Before going on to consider the reasoning that lay behind those subjects that said mental illness should not be regarded as medical problem. A few general points must be made about those who equivocated. By stressing as most of them did, that it must also be seen as a "psychological, social, political and moral problem", as 3507 expressed it, such lay staff were witholding legitimacy from the claims that many 'doctors' in particular make that mental illness is largely a medical problem. They are further

(1) One of the ways in which the dissidents differed from the others was their rejection of this sort of reasoning.

concerned to extend their own mandate in the area of the neurosis, and personality or behaviour disorders. As several pointed out "the psychoses are a medical problem, but not the neuroses" (2500) (1). While many were unsure of the extent to which there are organic causes of mental illness, nearly all such lay staff 'reluctantly' accept the need for drugs even when they do not believe they cure. The consequence of this acceptance was noted by 3502

> "... but then we are using chemistry a lot to reverse or suppress symptoms, and certainly it's a medical problem if you are going to give people things to change the chemistry of their bodies. So long as tablets are used the doctors will be there to prescribe them" (2).

As nearly all the psychologists and social workers, with the exception of a few of the dissidents, either welcomed or resignedly accepted the 'use of tablets', then they must come to terms with the consequences that this has upon the social structure and the responsibility that this gives the psychiatrist over the patient's health.

Some of the lay staff who were opposed to mental illness being a medical problem simply asserted that "no, it should not be" (3203) without providing any explanation for this view (3). A few of them did, however,

(1) "I can see a need for physical treatments, there may be a physical base, but even so the psychological aspects are very much neglected by the doctors. This is where psychologists can contribute" (2500), as he went on to say.

(2) 3606 who was working upon the special therapeutic community ward within Ashbury in fact located what she saw as a greater reliance upon the doctor and on medical therapies with their having to take patients from a catchment area. This meant that they could not be so selective and had led to an increasing number of 'medical problems' upon the ward.

(3) Attention should be drawn to the way that all the psychologists at Oakdene unanimously regarded mental subnormality as a 'social and educational problem'. As 2402 pointed out "The bulk of the patients problems are social, educational and psychological. In only a very few cases are they medical, and such at are, are mainly of a GP kind. The medical model is as wrong for subnormality as it is for mental illness, if not more so. But to accept this would threaten the doctors existence so they fall back upon this medical responsibility thing - they are threatened by the presence of the psychologists". As Table 20a shows, two of the Oakdene psychologists were regarded as equivocal for their more 'moderate' views on mental illness. Significantly, both of the social workers at Oakdene stressed how both mental illness and mental subnormality were very much medical problems.

explain their grounds for believing it should not be a medical problem. Such explanations tended to reflect the 'anti-psychiatry' critique of the medical profession, for example

> "I think that 'mental illness' is a personal and social problem, and that to see it as a medical problem is to remove from it the personal and social factors involved in the distress of the patients. In fact social is more micro social than macro social. I think that the current emphasis that is being employed by medicine in seeing 'mental illness' as a disease process serves both to alienate the patient from that part of himself that is the cause of the distress and to alienate him from others. Although I think this process of alienation and its reification into 'illness' serves fantastically good defensive function, both for the patient and others around him" (2804).

In the analysis of the ideological types other quotations were given that illustrate this point. For, as was noted in these earlier analyses, one of the most important dimensions of the dissident mode of response was their attack on the medical model of mental illness and their grasping for an alternative. Not that some of the therapists and professionals were not also dissatisfied with the medical model. Some were claiming to be 'countering it' by 'emphasising the social and psychological', or "not finding it necessary to use it at all" (2900), but such criticisms were allied to other comments stressing how these approaches were "not mutually exclusive" (3511). With the exception of a few therapists in the local authority, none of the other therapists or professionals can be seen as making a claim to have a complete alternative to the medical profession in the form of psychotherapy and casework. This can be illustrated by reference to the way that the majority of lay staff (around 80%) either thought psychiatry to be essential for the treatment of mental illness, or were equivocal over this question (see Table 20b). Instead most therapists and professionals reasoned in such a way as to suggest that they could <u>supplement</u> the psychiatrist, and even provide the 'real' therapy, but that they could not replace him. For example, one of the professional psychologists who was in many ways critical of the medical domination of psychiatry argued that

> "... Some illnesses are very like physical illnesses and for these you need a doctor. At the other end it is often the disturbed relationships with other people that we call an illness. I think that things are changing and that we are going into a new era of stressing disturbed personal relationships. If this is the case and we can hive off physical mental illness for whatever medical treatments are necessary, then psychologists could play a bigger part, providing we are able to develop techniques of interpersonal 'engineering'" (1) (2903)

More specifically there were many comments such as "Psychiatry is essential because of the psychoses, the drugs do cure after a fashion, even if the patient subsequently needs psychotherapy" (2503). Or as another psychologist pointed out

> "We cannot say that psychotherapy and psychologists are getting patients out of hospital. At the moment drugs and custody are doing more for most patients than the groups that are held on the wards" (2904)

Or as one of the therapists put it "With the psychosis you have to have drugs and ECT - without them we wouldn't be anywhere. All the psychoanalysis and casework in the world wouldn't cure psychosis" (3510) (2). As noted in the analysis of both the 'professional' psychologists and 'therapist' social worker category, a central element of these ideologies is the belief that they can contribute towards the therapy of the patients. However, what emerges out of the way they represent the importance of psychiatry, is not a total abnegation of their own claims to be 'therapists' as well, but rather a definition of their own role in terms that derive from the medical profession.

This process was very clear in the way the welfare workers see themselves as aides for the doctors, but the process is less obvious and more diffuse with the therapists and professionals. At one level it can be

(1) Attention was drawn to such voluntarism in the analysis of the 'professionals' in Chapter 6.

(2) As 3511 said "Medication often makes possible what we do in psychotherapy, it speeds it up, makes it possible. I see the two as complementary, it's not either or".

shown in the way they accept the major diagnostic categories of the psychiatrists, as one therapist observed

> "I now know a lot more, I am now able to recognise and differentiate between types of illnesses and the need to select patients for certain types of therapy ... there is an organic aspect to something like schizophrenia, so that while you might be able to do some casework, it would not be like the psychodynamic work that you could do with a neurotic patient or with someone with insight. Schizophrenics do not have much insight usually, though some do. It's difficult to give insight to a schizophrenic" (3510).

Others expressed what can be seen as a form of medical pessimism or fatalism about some conditions, while others noted how, for example, 'little could be done for depression without physical treatments' (3601) as if this were proven fact. In the analysis of the ideological types in Chapter 6 there were references to the different ways the lay staff viewed mental illness. What should be noted currently though was the way many of them used the same concepts as the psychiatrists. Having accepted (or learnt) that some conditions are 'medical problems', many therapists and professionals impose upon themselves, or willingly accept, the idea that they can only contribute towards the treatment of certain conditions. Given the present state of the understanding of mental illness, it may well be 'realistic' to accept that certain conditions can only be 'treated' with physical methods, which must necessarily rest in the hands of the medical profession. However, while many lay staff indicated a consciousness of how things might be different, the majority would appear to have internalised and thus in a de facto sense, legitimised, what might be taken as the 'psychiatric professions consensus' that the doctors must decide what is, and what is not, mental illness, before the other professions can play their part. In this sense many therapists and professionals can be considered to be <u>accommodating</u> themselves to the medical profession, even when they are critical of the latter's excesses or deficiencies.

Much more critical than either therapists or professionals were the dissidents from both lay occupations as well as from among the psychiatrists.

Although the same term is being used with which to describe the dissidents from within each of the occupations, they form a rather 'unholy alliance' when considered as a group. However, perhaps they show greatest unity in their critique of the practice and functions of psychiatry. Unlike the others who were critical of the inadequacies of psychiatry, the dissidents were often critical of their own occupation as well as of psychiatry for its wider political role. One dissident psychologist, having expressed considerable uncertaintly and anxiety about 'knowing so little in psychology and psychiatry' and how the 'more I get to know about psychiatry, the less satisfied I am with it' went on to comment that

> "Psychiatry is being used to justify the removal of people from the community, to be locked up and drugged. It's the establishment that wants this and that's what we do. As psychologists we merely help to legitimise the psychiatrists actions. I don't know how useful this is for the patients, we cannot know - I think" (2905).

Another dissident sought to locate the present power of the psychiatrists with the history of the medical superintendants

> "In terms of these places being used as controlling institutions, then the psychiatrists are very important as they are the only people who can use drugs and legally detain people. They are the mind police of our society. Also as a profession, they are very conservative, hierarchical, rigid and usually committed to the dominant values of our society. Since they have the organisational power they are very important - this comes from the traditional power of the doctors. Originally they only used to visit these places, otherwise they were run by the nurses and the attendants. Then on came the medical superintendants, who were like Gods in these places. It's almost the same now - these places must be changed but it seems bloody impossible. I very much resent the doctors because they have the power and I haven't to put it at its crudest. It has a lot to do with how one looks at patients. I think that most patients can decide for themselves what they want to do, and usually do so - the psychiatrist merely validates someone elses decision. If there were no psychiatrists these places

wouldn't be hospitals - they might be something else" (2801) (1). The question of what the dissidents would like hospitals to be will be returned to after pointing to the significance of some of the comments in the above quotation. This quotation was given in full, as it shows more clearly than other similar ones, how the dissidents differ from both the professionals and therapists. In particular this psychologist locates his criticism with the wider social structural position of the medical profession as well as with its position within hospitals (2). Further, there is an implicitly political criticism of psychiatry for imposing value judgements upon the behaviour that it regards as 'mental illness'.

In the analysis of the category of 'dissident' in Chapter 6, reference was made to the way most of the dissidents wished to regard mental illness as being, as 2501 put it, "a form of human experience to be understood and shared instead of being suppressed and invalidated by drugs". Several referred to wishing mental hospitals could be like 'asylums', where as 2804 said "people can escape from their problems if they want. Where they can live through experiences and sort something out, in a relatively peaceful atmosphere". While the above psychologist went on to accept that pharmocological therapies can have a valid 'supportive role', one of the other dissidents was opposed to them on the grounds that

(1) See 1516 for a similar, if less detailed view of psychiatrists as agents of social control (p.187). It is significant that only a few of the lay staff apart from the dissidents made anything other than fleeting references to this latent function. This suggests the way such lay staff like to think of themselves as working in a hospital, with 'ill' people as a means of enhancing their own status.

(2) Therapists and professionals, when criticising the psychiatrists, either neutralised their criticism by suggesting that it was largely a question of personality, or located the problem with the training of the psychiatrists, with such comments as "doctors have such narrow and rigid educations - they are tied up and handicapped by their mechanistic training when it comes to understanding a patient in psychotherapy" (3208).

"Self discovery is painful and to alleviate the pain may prevent discovery. Being 'mad' should be a way of life that can be considered feasible for those that want it. I find it very disturbing that the average psychiatrist decides what experiences are valid and how a person should live" (2502) (1).

The question of how far mental illness should be a medical problem, and the extent to which the lay staff consider psychiatry to be essential for the treatment of mental illness, can thus be seen to be of considerable importance. Through the analysis of the lay staff's attitudes to these questions, several of the themes being explored through this study have been elaborated upon. However, before considering the bearing that the material presented so far, has on these themes, it is necessary to examine in more detail the lay staff's views of the psychiatrists' expertise.

The lay staff's views of the psychiatrists' expertise

An overview of the various activities that were mentioned by the social workers and psychologists, as being 'essential tasks' of the psychiatrists is given in Table 21 below.

Table 21: The social workers' and psychologists' views of the psychiatrists' essential tasks

	SW		Cp		Ps+
Diagnosis and 'treatment'	18		11		38
		= 35		= 21	
Diagnosis and 'physical' treatment*	17		10		22
Psychotherapy**	5		1		13

(1) He went on to locate the problem "not just with medical training, but with the philosophical beliefs in our society".

Table 21: (cont)

	SW		Cp		PS+	
Legal responsibility	4		6		-	
Leadership/direction	8		2		12	
Coordination	4	= 14	5	= 9	14	= 36
Guidance/support/teach	2		2		10	
Custody of patients	3		2		3	
Admit/domicillary visits	2		-		4	
Unclear/don't know	2		7		-	
Should by psychotherapy	4		3		2	
Research	-		-		2	
Management	-		-		5	
Policy making	-		-		3	
Being a doctor	-		-		4	
Overall understanding	2		-		5	

* Within this category are included 10 social workers and 4 psychologists who referred to 'only' carrying out the physical treatment. Also among the psychiatrists there were a further 10 mentions of looking after the 'general medical condition of patients'.

** The 'low' figure for the psychiatrists contrasts with what they said about themselves when asked specifically about psychotherapy (see Chapter 9).

+ This is a modified version of Table 15. This column has been included to aid comparison. The different expectations surrounding 'leadership' being the most notable.

Many staff mentioned more than one task, although as the table shows, there were also a large proportion that described the psychiatrists tasks in such general terms as 'treatment' or 'diagnosis and treatment' without going into much more detail. As one local authority social worker

commented "They provide the treatment and carry out the diagnosis" (3510), or as a social worker in Ashbury hospital noted

> "The medical role of diagnosing the mental condition and prescribing the treatment. In general acting in a therapeutic and stabilising way with the patient" (3604).

Or as one of the psychologists at Woodlands simply put it "Treatment, accepting that he is the person who is responsible for the patient's general well being" (2504). Large proportions of both the social workers and the psychologists indicated through their replies that they considered the role of the psychiatrists should be <u>restricted</u> to that of dealing with the 'medical aspects of the patients' conditions. As already noted, most of the lay staff accept the need for physical treatments and thus as one psychologist observed "You do need medical knowledge to treat many people, and the psychiatrist is the only person who can push drugs into patients" (2503). Some were more critical, such as

> "I accept that you do need to have someone to check on the physical condition to eliminate brain tumors, etc., but this could be carried out by an ordinary doctor. I think psychiatrists should at present only deal with medical matters, but of course they don't" (3504).

As Table 21 indicated there were many social workers and psychologists who appear to hand over the question of 'diagnosis' to the psychiatrists. This confers legitimacy on the claims of many psychiatrists observed in the chapter on the medical mandate that tthey must decide the diagnosis, before any other staff do anything with the patient. However, whereas many psychiatrists believe that they have a natural prerogative to either prescrible some form of psychotherapy for their patients, or to carry it out themselves, none of the psychologists, and only 5 of the social workers, mentioned that psychotherapy was an 'essential task' of the psychiatrists. Indeed, the opposite was the case with several lay staff talking of how the psychiatrists should <u>not</u> carry out psychotherapy. As one psychologist put it

> "I see their skills to like in the area of organic psychiatry where there are identifiable organic conditions. They are not trained to

carry out psychotherapy, and I find it galling to say the least, the way they presume to decide who shall and who shall not be treated in this way" (2907).

The particular question of who should carry out psychotherapy will be taken up again further on; all that need be said about it at present is that very few of the lay staff saw the psychiatrists as being experts at it (1). However, as has been argued earlier on, they have to come to terms with the fact that the 'patients are the doctors' patients' and in this sense are free to decide what happens to the patient. This acceptance, and in some cases expectation that the psychiatrists will take certain important decisions, can also be illustrated by considering the lay staff's attitude to the claim to hegemony being made by many psychiatrists.

This claim was considered in the previous chapter, and it can be illustrated by reference to Table 21. Whereas the psychiatrists were almost unanimous in claiming a 'leadership' role for themselves, less than 40% of the social workers and only a third of the psychologists mentioned this as being a necessary task, even when a very broad view of 'leadership' is taken (2). Significantly, 8 of the social workers and only 2 of the psychologists mentioned 'directive' leadership. Many of the former being 'welfare workers' who were often quite specific about the need for medical direction. In contrast, many of the psychologists (especially the 'professionals') stressed how the psychiatrists should coordinate the other staff's activities, only because they were legally responsible. An example being one of the principal psychologists

"There are two main tasks, the first is the application of the medical model to the situation that the patient and his environment present,

(1) Several did, however, differentiate between those psychiatrists who had trained as psychotherapists and those who had not.

(2) That is by combining not only 'direction' but also 'coordination' and 'liaison' as well as 'guidance', 'teaching' and 'support'.

> and secondly to coordinate the work of the various members of the clinical team. I want to emphasise that I mean coordinate - NOT lead. Where these two go together the concept of the psychiatrist as leader can be misleading. The second role comes from his statutory obligations and the first from his training" (2900).

In this way again a prescribed and limited view is taken of the psychiatrists' expertise. They are recognised as having a certain role to fulfil, but legitimacy is witheld from the wider claims that psychiatrists make. Indeed, a small number of lay staff characterised the psychiatrists, as merely 'acting in the communities interests' as 'agents of social control' and as 'guardians of the lunatics'. Several others made derogatory comments about psychiatrists being merely 'pill pushers', 'shock box technicians' and in other ways suggested that they were 'not only incompetant, but dangerous as well'. However, it should be stressed that this view was very much a minority view, the most derogatory comments coming from the social workers in the local authority.

As the table indicates, there were also several references to such activities as 'domicillary visits', 'admitting patients', having an 'overall understanding' and 4 referred to how 'it depended on what sort of person they were'. Several were unclear and 'found it difficult to say' what the psychiatrists tasks either were or should be, though many of these did mention activities listed above. However, bearing in mind the different views of the separate sub groups, such as the way the welfare workers and testers recognised the psychiatrists' overall mandate, the lay staff held a much more restricted view of the latters'expertise', and in many ways sought to suggest that the 'real therapy' was not carried out by the psychiatrists. The question of what they considered 'real therapy' to be, will be examined in the following chapter.

Conclusions

This chapter has shown how on the one hand the overwhelming majority of the lay staff consider that mental illness should be more than a medical problem. In this sense they can be seen to be encroaching on the more exclusive medical claims (bearing in mind the fact that the psychiatrists cannot be regarded as being a unity over this) that mental illness is a primarily medical problem. On the other hand, the overwhelming majority of lay staff also regard psychiatry to be essential, to a lesser or greater extent, for the treatment of mental illness. Many of the staff concerned would not see these as divergent or contradictory tendencies, and would seek to integrate them by suggesting 'how different psychiatrists were from one another', or how the medical model and therapies could be used in some situations, but not in others. By so doing they might either seek to restrict the relevance and the role of psychiatry to routine activities or those that they devalue. Alternatively, by stressing the importance of 'team work' they would suggest how they could increase their own sphere of influence, while offsetting the limitations of psychiatry. For with few exceptions, most of the lay staff valued the psychiatrists primarily for their 'functionally indispensible' tasks, such as providing physical treatments to suppress symptoms, control disturbing behaviour, relieve 'endogenous' depressions, and generally tranquillise. Related to this is the 'dirty work' associated with compulsory orders, detentions and transfers to locked wards. Most of the lay staff do not want to take this work upon themselves, although they often recognised that much of the psychiatrist's power and influence flows from his control over these resources and procedures.

In various ways the lay staff can thus be seen as accepting certain

claims being made by the psychiatrists, although they do not accord them the legitimacy that psychiatrists appear to believe they receive. However, the recognition they grant to the psychiatrists claims to carry out the 'diagnosis', means that the lay staff in effect accept the right of the psychiatrists to decide which patients are amenable to 'non-medical' forms of therapy. In the earlier analysis of the eclectic ideology, and again in Chapter 7, it was noted how many psychiatrists appeared to believe that they did not limit what the other staff did. In this chapter attention has been drawn to the way some of the psychologists and social workers were claiming that they provided the 'real therapy'. In Chapter 10 there will be an analysis of the extent to which the lay staff felt themselves free to contribute, but before considering this question it is necessary to explore in more detail the nature of the contribution that the social workers and psychologists were claiming to be able to make.

CHAPTER 9

PSYCHIATRIC 'EXPERTISE' AND THE DIVISION OF LABOUR AMONG THE MENTAL HEALTH OCCUPATIONS

Summary: This chapter contains four sections, the first two dealing with the social workers' and the psychologists' views of their expertise. As it appears that members of both these occupations are claiming to be able to carry out 'therapy', the nature of the division of labour between all three occupations is then considered. As most of the overlap between these occupations appears to be over the carrying out of psychotherapy, the question of who should carry it out, is considered in the final section. This chapter will also examine the extent to which the members of the various occupations are 'qualified' to carry out therapy, and indeed will note the way many staff consider ability as a therapist to be a matter of personal qualities, not formal qualifications. Attention will also be directed to the various dilemmas that confront both of the lay occupations, when they seek to become more involved in therapy.

Introduction

In Chapter 7 there was an analysis of the psychiatrists' expectations and evaluations of social workers and psychologists. Certain important points emerged from this analysis; to begin with the psychiatrists were themselves shown to be divided over the extent to which they held 'restricted' or 'open' views on their appropriate contributions of the lay staff. More important than this though was the suggestion that psychiatrists, as part of their general medical mandate, tend to devalue or undermine the lay staff's contribution in anything other than their traditional tasks. They

did this by suggesting that either any other staff could perform these activities, or by personalising their abilities. As a consequence they detracted from any claims that the lay staff might be making to have superior knowledge of certain activities. Bearing in mind the more favourable evaluation placed upon the social workers than the psychologists, this chapter is initially concerned with exploring the ways in which the lay staff, are seeking to expand the range of activities that they can perform.

To a certain extent some of the issues to be dealt with in this chapter have been noted before, especially in the chapter on the ideological types. Throughout this chapter there will be references to the ideological types that were previously identified, even though the aim is to explore the features that are common to all the social workers and all the psychologists.

The social workers' view of their own expertise

> "Social work is a professional service with the object of helping the person towards a more satisfactory way of living whether on a general basis or on a specific problem. The techniques include those of special resources, such as community agencies, and a capacity to understand what the problems are - which are the most important and how individuals can cope effectively. It could be a one to one situation or taking on a whole family as a client, a whole group or even a whole community" (3507).

The analysis of the difference between the therapists, welfare workers and dissidents drew attention to the quite different 'work' that they thought social workers should be doing. For all of them, however, there was a recognition that they were responsible for putting the patient in touch with other social services, for contacting relatives, gathering information about the patient from outside bodies, and for resolving practical difficulties that face patients when suddenly cut off from their previous life. As pointed out in the analysis of the psychiatrists' view of the

social workers, it is these activities that make social workers 'essential' in their eyes. Many recognised how the efficiency of their units in returning patients to the community would be impaired without social workers doing 'their job properly'. From the social workers' point of view, many of these tasks "could be carried out by a suitably trained secretary" (3602), and indeed at Woodlands, there were secretaries who handled most of the financial problems of the patients. However, while the welfare workers saw their work to be primarily of a practical nature, there were others who noted how

> "While I would like to think that the essence of the job is more central to treatment than merely doing practical things, I have found that recently I have spent most of my time doing liaison work and finding accommodation, especially hostel places and such menial things as making sure that someone's rent has been paid" (3606).

Thus, while some social workers seek to divest themselves of such 'dirty work', others, including some dissidents, believe that social workers should restrict themselves to practical, welfare activities. An interesting parallel with the 'professional' psychologists emerges here, for in the same way that many of them wished to dissociate themselves from their testing role, some of the therapists also thought it "unfortunate that we are identifiable to the other staff by the fact that we go outside the hospital and arrange things for the patient" (3506). But in the same way as most psychologists believe there is some value in their assessment methods, the therapists also value some of their practical welfare activities.

Table 22 below provides evidence for the way all the social workers made some reference to their 'welfare' activities. The limitations of such tables should be borne in mind as they are only given to provide an indication of frequency that certain activities were mentioned. One of the reasons for drawing up this and similar tables was to enable certain comparisons to be drawn. If reference is made back to Table 16 on page 214 it is possible to compare the psychiatrists' views on the social workers'

tasks with social workers' own views. In particular it is evident how only a few psychiatrists expected the social workers to carry out 'psychotherapy/casework'.

Table 22: The social workers' views of their expertise, as summarised in the number of references made to certain tasks*

	No	%
Welfare tasks		
Gathering information	8	21.1
Liaison with local authority services	11	28.9
Social resources	9	23.7
Practical assistance	10	26.3
Welfare tasks total	38	100.0
'Mixed activities'		
Supporting the patient	8	21.1
Relating with the patient	8	21.1
Rehabilitation	7	18.4
Total	23	60.5
Therapy tasks		
'Therapy'	4	10.5
Psychotherapy	8	21.1
Casework	9	23.7
Group therapy	6	15.8
Therapy totals	27	71.0
Miscellaneous tasks		
Social problems	3	7.9
Changing attitudes	2	5.3
Statutory duties	3	7.9

* These figures are derived from answers to question one in the interview schedule. At other points in the interviews other tasks may also have been referred to.

If the social workers were in something of a double bind over their welfare work, this was also the case with their therapy work. With the exception of a few of the local authority social workers, who believed that only they carried out psychotherapy or gave 'real therapy', most of the therapists recognised that they were not alone in giving psychotherapy. Certainly, several believed that "social workers usually know more about psychotherapy than the average doctor coming new to psychiatry" (3511), but most of them acknowledged that other staff also practiced psychotherapy. Most social workers, like other staff, related ability as a 'therapist' to personality and other particularistic factors, even though some also thought that their training made them more suited to giving this sort of therapy. Further, as 3500 expressed it

> "Much of what we do given the setting and the agency, is much more akin to therapy than what the psychiatrists do in out patients sessions, when they only see the patient for 15 minutes".

However, while some of the therapists mentioned their use of various techniques (1), there were others who referred to how they

> "tend to see social workers as persons not as technicians. I think that the things that we do are based more upon the relationship as such, rather than on the interpretive and technical aspects of the relationship. While I consider that I do psychotherapeutic casework, I do not like the concepts and feelings of psychotherapists as being less emotionally giving" (3505).

Thus, while some of the social workers, that is the therapists, could be seen as advancing a claimed mandate to be able to treat"the emotional and relationship side of the patient" (3601), or to be the "therapist for

(1) 3500, a trained psychiatric social worker, also talked of how "I do not see social workers to be potential analysts, but we do use modified analytic techniques with particular patients, by giving ego support, presenting reality, looking at defences and using the transference situation. That is using psychoanalytic techniques in a very broad way". In other words there were a few (psychiatric) social workers who considered themselves to be skilled in certain psychotherapeutic techniques.

the family" (3506) or to be a psychotherapist, the expertise that they claim to possess is often in their own terms, related to

> "what they are like as human beings, what sort of person they are and how talented they are in relating to other people. This is more important than having been on courses or acquired qualifications". (3606)

A few further general points need to be made about the tasks or activities that social workers thought they should carry out. Or, to put it another way, the tasks that they did not mention, need to be considered. Very few of the hospital social workers mentioned playing any part in deciding on the admission of a patient or in taking any of the subsequent decisions about the initial treatment, diagnosis, or placement of the patient. Further, very few (only 4) mentioned how social workers might or should take over 'leadership' functions, or be 'responsible' for the patients. Some social workers did mention how they played a part in deciding on discharge and some were primarily concerned with rehabilitation, and thus played an active part in these matters. However, overall, while many social workers felt there was no clear cut division of labour in the area of therapy, it is clear that many took it for granted, that certain activities belonged to the province of the medial or nursing staff (1). In this way they imposed boundaries or limitations around themselves that appeared to stem from the often reiterated belief that "when working in a hospital, you have to accept that the patient belongs to other people as well as to yourself" (3400).

One of the dilemmas confronting the social workers is that they are

(1) Some of the local authority social workers in fact thought that they 'decided' upon admissions in so far as they acted as one of the gate-keepers to the local mental hospital. Some thought that it was only their own failures that were referred on to the hospital.

the members of staff who are expected to provide 'social histories' on the patients. However, while they may believe, as 3512 did, that

> "My reports seem to be considered of great importance, especially when one is talking about discharge - they are referred to constantly as the home situation information is considered of vital importance".

Most of them appeared to define the task to be one that had to be carried out in the terms that were specified by the psychiatrists, or as 3508 said

> "I think that it is up to the social workers to provide as much information for the doctors as possible to aid the diagnosis, for only we can give the background information and see the patient in his family setting".

For, as one of the dissidents noted,

> "All I am expected to do is to provide short case histories, but having provided this information it does not make any difference, it's only treated incidentally. There is a medical diagnosis which is arrived at by the doctors upon which treatment is based, and then a 'social' diagnosis which I provide. Occasionally, it is referred to, but only for information, not as a means of understanding the patient as a part of a wider social situation" (3503).

The dilemma then is that while many social workers advance claims to have expertise in 'evaluating the social situation', the 'patient's life outside the hospital', or in 'seeing the patient in his family setting', which they believe or hope will counter-act "the one sided picture that the doctor has" (3509), they find that they have no control over how this information is used. Clearly, it plays a part in making the social workers essential, for consultants who attempt to have a rapid turn over of beds, can only do so if they can find ways of transferring patients to other institutions, such as hostels or old people's homes, if not back to their own families. Interestingly, when asked about how much influence they thought they had over what happened to patients, those social workers who thought they had any, nearly all mentioned 'discharge' as being the area over which they had influence (1). Significantly, several social workers felt they only

(1) See 3512 (above), also 3602 "With Dr C I can influence such things as the date of discharge, but with Dr B I don't even try, as he decides things and simply ignores what everyone else says".

had influence through the use of delaying tactics, as they had control over the means of discharging patients. One specifically referred to the way she could "misrepresent the transport situation to the doctors if I want to delay a discharge" (3503), while others referred to how they could 'manipulate the situation' through their 'control' over access to hostel accommodation, contacts with relatives and the finding of jobs.

To return to the original question posed at the outset of this section, namely the nature of the 'work' that social workers felt to be their own, a few general remarks can be made. To begin with, because the divisions among the social workers are more apparent than among either the psychiatrists or psychologists, it is not possible to talk about their 'claimed expertise' without relating it to other facets of the differences between them. While there were some social workers, such as 3507 quoted at the start of this section, who appeared convinced of the 'professional' contribution of social workers in various activities, the majority did not appear to be making such global claims. There were some, especially a few social workers in the local authority who made trenchant claims such as "social workers give the only real therapy" (3204), but the majority appeared to define their contribution as being less important than that of the psychiatrists. This did not mean that they did not consider themselves to be essential, and they were certainly more confident of their value than the psychologists. Only 4 (10.5%) thought they were 'not at all necessary', 15 (42.1%) were somewhat equivocal in expressing major qualifications, while 18 (47.4%) thought themselves to be essential with only minor qualifications.

Clinical psychology as 'more than testing'

> "Clinical psychologists are very unclear themselves as to what their role is. There is a problem in that psychologists are being trained as professional people but without a clear field to themselves. They have a confused notion of being professional and of being involved in decisions affecting themselves and their clients. There is still this test bashing image, but only a few would be happy to accept this" (2401).

In Chapter 4 it was pointed out how clinical psychology was introduced into the mental hospitals in order to provide a diagnostic assessment service for psychiatrists. It was also noted how clinical psychologists appear to be divided as to the value of such work, while in Chapter 6 it was observed how the majority of the psychologists interviewed for this study, did not wish to restrict themselves to such activities. Bearing in mind the 'technical' nature of such work, it might be thought that an aspiring profession would seek to develop such techniques, in order to challenge the more established profession from a position of 'scientific' strength. The aim of this section is thus to first of all examine the psychologists' attitudes to their 'testing' work, and then to examine the dilemmas they find themselves in, when they seek to abandon such work.

Table 23 below is a similar one to that given on the social workers on page 251. Thus the same qualifications apply to it as to the previous one. On page 214 the comparable table giving the psychiatrists' views of the psychologists was given. More clearly than with the social workers, the psychiatrists barely recognise the psychologists for anything other than their more technical functions.

Table 23: The clinical psychologists' view of their expertise as summarised in the number of references made to certain tasks*

	No	%
Diagnostic testing and assessment	26	96.3
Research	17	62.9
Teaching	16	59.2
Therapy	9	33.3
Psychotherapy	7	25.9
Group therapy	6	22.2
Behaviour therapy	6	22.2
Total number re. 'therapy'	28	
Consultancy	9	33.3
Changing attitudes	6	22.2
As a person	5	18.5
Vocational guidance	3	11.1

* These figures being taken from the replies to the first question only - see questionnaire in Appendices.

As the table above demonstrates, nearly all the psychologists made some reference to their testing work, even though some did so to note the "standardised, routine and boring nature" (2907) of such work. Clearly, those psychologists who have been designated 'testers' valued this work, and some of the other psychologists, especially at Oakdene, drew attention to the importance of such work in assessing the patient's degree of handicap. However, many other psychologists were dissatisfied with such work because of the way "We are regarded as a sort of technical assistant, it's like sending for an EEG - just to get an answer back" (2504). In other words, quite apart from the content of the tests themselves, many psychologists recognised that to be receiving referrals from the psychiatrists for further

information on a patient immediately defined them in an auxilliary relationship towards the psychiatrist. This was especially the case where the psychologists only sent written reports to the psychiatrist concerned, such that the latter would then decide upon the relevance of their information (1). This was the case at Woodlands and sometimes the case for the psychologists at other hospitals. As one of the Woodland's psychologists said

> "The fact that the doctor refers the patient to you affects what you are doing. If someone refers a patient and you write a report, you feel that you would like to be doing something useful. But at the present you get no feedback at all. The impression is that very little notice is taken of the report, so if the main job is a testing one, then you feel that you are doing a worthless job. If what you say is in line with psychiatric thinking then it is accepted, but if it is counter to what the doctors think then it is rejected - the tests are dismissed as worthless. This is why psychologists feel themselves to be in atrap - they are all the time being double binded by the psychiatrist. There is a need for the psychologists to break away from this altogether" (2501).

Quite apart from those few psychologists who placed greatest value on testing, there were others, like 2501 above, who thought it had some value, providing they were in a position to interpret their own tests. At Oakdene there was a running conflict over precisely who should interpret IQ scores, as one of the psychologists said

> "the doctors here have a very adolescent view as to what they think we should be doing, they are so adolescent that they think they can interpret our tests as well as we can. We must do our own testing because of the skills that it requires - though we should be choosier about the patients that we accept for testing" (2402).

(1) One of them described how at her previous hospital "I was just at the end of a factory belt with slips of paper saying 'IQ please'. I could not get any further details. I would only send back a report, against the Shapiro dictum that reports should only be for the records, whereas the actual contact should be direct and personal. I could sometimes attend a ward round but it would only be to speak about a patient, and then I would leave the room" (2901).

In contrast, in some other hospitals where the psychologists did not attach the same importance to testing as in Oakdene, there was less concern about this (1). Indeed, several psychologists themselves pointed to how "the psychiatrists are wise to bear the clinical picture in mind, after all our tests are not infallible" (2500). Even if the majority did not go so far as 2504 in saying "We should be admitting that our tests are useless and also be asking whether we can ever have useful tests". What emerges from the majority of psychologists was a sense of unease, or confusion over the value of their tests and more particularly with the way being seen as only a tester, defined them as auxilliaries in relation to the psychiatrists. At the same time, however, the majority did not want to abandon this work altogether, as 2905 expressed it "I feel unhappy that we have built up a profession on something so irrelevant as testing, but it is a way of being included". Or as 2901 pointed out

> "Our only unique contribution is the use of so called 'scientific instruments' in the form of tests. But we are not sure what we are measuring, or how we are doing it, though I think there is something to be offered by testing - we can help with the assessment of a person's resources" (2).

(1) At one of the hospitals, the principal psychologists pointed out how he used his secretary to both administer and score some of the more routine tests, while he only interpreted the 'trickier cases'" (2800). While at Woodlands the psychologists had advised the junior doctors on the geriatric wards about the use of a simplified 'query dementia' test, so that they would not be bothered by such referrals.

(2) It should be noted that there were a few psychologists who carried out projective testing, and clearly considered it to be of a higher order than other forms of testing "In the exploratory testing I use the projective tests, the Rorschach, TAT and Wexler. I am not very interested in the form filling type of test. For me testing should be creative assessment - it shades into therapy" (2904). Similarly there were references to vocational guidance as being a specialist assessment service.

Whereas the social workers can be seen to be essential for treatment programmes because of their control of access to social resources, the psychologists, in their own terms, are 'luxury elements' (2907), or 'largely irrelevant' (2600), if not merely like 'path lab technicians' (2505) for their assessment work. Indeed, only 7 (25.9%) of the psychologists seemed to consider themselves to be 'essential', over half of them (14, that is 51.9%) expressed major qualifications about their importance, and 8 (29.6%) said they did not see themselves to be 'at all' essential. No psychologist had the illusion that the psychiatrists relied on them, or were dependent on them to provide them with certain information before deciding the fate of a patient (except in borderline cases), although some thought they could have more influence if they were present when referrals were made (1). At one of the hospitals (Oakdene) the psychologists felt that the other staff did not regard them as working if they were not seen to be testing patients (2). The problem for the majority of psychologists was as 2905 put it, that "we entered on this silly testing basis byt we need to develop it in other ways if we are to do anything worthwhile". Just how they are seeking to develop their role will now be analysed. Before doing so, attention must be drawn to the problem that movement away from a testing role creates for the psychologists. That is, once they abandon their stance

(1) The exception being two of the testers, one of whom commented that she provided such detailed reports that the doctors 'dare not, not use my service'. While one of the others (2600) did some assessment work upon brain damaged patients - as he observed "No one else can do this except the psychologists - though the patients are rarely psychiatric material".

(2) This was in part a reflection of the general antagonism towards the psychologists expressed by some of the doctors and the two social workers. The Department of Health and Social Security in fact requires that the psychologists within subnormality hospitals provide them with information on the IQ scores, etc. of all patients. Their resistance to doing this, provided one of the critics of the psychologists the grounds for alleging "They never do anything as far as I can make out, except the principal who seeks to aggrandise himself through outside lecturing upon the Activity Centre" (3400).

as technicians (whether as testers or researchers) then they can no longer claim to possess any distinct expertise of their own. That they are not alone in this, will be pointed out further on in this chapter. This point should be borne in mind during the analysis of the way some of the psychologists, especially the professionals, were seeking to expand the range of their activities. The earlier outline of the 'professional' ideology can be referred back to as providing further illustrations of this.

As noted in the description of the professional ideology there were several psychologists who wished to define themselves as playing a consultancy role towards the other staff. For 2601 this meant that he "went beyond merely presenting test scores to offering a sort of consultancy role". Others elaborated on this to outline eitherhow this would stem from the psychologists research work, such that

> "The doctors should put into practice what they learn from us, in dealing with the patient, the social organisation of the ward and in problems of communication with the other staff. They should make decisions that incorporate what we have to offer in the form of information" (2500).

Others saw such work as including actual involvement with other staff "when changes are made in ward organisation, or the treatment of patients" (2903) (1). There were others who went beyond this to argue for a total involvement of psychologists on the wards in various 'action research' projects as 'organisational consultants' (2804) (2). In contrast, another psychologist who stressed the research aspect of their work, talked of "looking at what causes mental illness and the evaluation of treatment and ward management

(1) As an example of this, he referred to the problem that a new doctor was having in persuading the nursing staff to have unlocked doors on a particular ward. The psychologist had been to meetings with the nurses, so that he could advise the doctor on how best "to communicate with them, and put over his views".

(2) It's not by chance that this psychologist had done his degree at Brunel University.

techniques" (2803). She went on to say that

> "I see the psychologist feeding the results of research to the doctors to enable him to make more valid judgements upon the value of certain treatments"

a view that was echoed by many other psychologists, who also saw psychologists as

> "having an overall view of the situation as we are one step away from the treatment situation, having had experience of it, yet not being responsible for it" (2502) (1).

It should be emphasised that not all the psychologists wished to approach such work in a researcher capacity as, for example, the principal at Woodlands did "If our activities are not research based, then we are going to end up in a poor state, we would end up like the doctors, not knowing what we are doing, with no basis to our working. We should not launch forth into activities without validating them" (2). Instead they saw themselves as acting as 'advisers' and 'tutors' to the other staff, either in a specifically educative capacity, as for example, when they were teaching psychology to the nurses and to the junior doctors for their DPM exams, or in more general sense, that almost amounted to a public relations exercise (3). As 2800 expressed it "... the role of the psychologists must also be to initiate an awareness of the psychological aspects of the way the team works". Several referred to the importance of their tutoring work with their own probationers, and how much of their own time was taken up by

(1) It should be noted how frequently such comments were made, especially by the professionals, though some of the dissidents made similar comments such as 2801, who claimed that "Our essential skills are, or should be in terms of social diagnosis - that is working as a social psychologist - working in organisations and feeding back to the others around you, what you think is going on".

(2) As noted further on in Chapter 10 this was one of the sources of conflict between himself and two of his probationers.

(3) As 2601 noted "I have already made an important contribution towards demonstrating what psychology can do - in educating people as to how they could use a psychologist meaningfully, while broadening my own scope as a result of this demonstration". 2900 also talked of "holding a seminar upon Ward H, where I give information to all the other staff upon the things that I know something about".

it. Several considered their teaching work with the nurses to be valuable as "a means of providing an alternative view of patients to that presented by the medical profession" (2400). Overall the various statements on this 'consultancy' role, that psychologists would like to see themselves having, amount to a confirmation, or more precisely an affirmation of their commitment to a reformist stance towards the institutions in which they work, as well as their attempt at extending their own occupational mandate. The significance of this reformism will be commented on in the next chapter.

Although there were many references to such activities as research, teaching and consultancy, there were very few who wished these activities to be the sole ones in which they specialised. Instead the majority of psychologists appeared to attach the greatest importance to their work as therapists. As already noted, it is the movement away from a purely testing role that has created many problems for psychologists, this being particularly so when they undertake therapy. Not only is it often hard for psychologists themselves to differentiate their own expertise as therapists from that of the other staff, but it also raised for them, the problems of access to patients, and of being accountable to the psychiatrists in a way that they never encountered when performing the limited role of assessment. These issues will be discussed in detail in the analysis of the social structural position of lay staff in the next chapter.

In the analysis of the 'professional' ideology, it was observed that such psychologists often claim to be proficient at several different types of therapy, from psychotherapy, through group therapy to behaviour therapy. It is not necessary to give further quotes to illustrate the varied way that such psychologists represented their work as therapists (1), instead the

(1) One further one can be given as providing an example "... I have so many roles here, one some wards I am a psychotherapist, which is exactly parallel with that of thesocial worker and the doctor, but on other wards I am a psychologist. I am trained at behaviour therapy which only I do, but the group and individual psychotherapy I share with the other therapists among the social workers and doctors" (2901).

focus is upon the extent to which psychologists were claiming to have distinct skills at therapy that set them apart from the other staff. For there were some who believed as 2500 did, that "psychologists have a greater knowledge of group dynamics and psychotherapy than the average doctor". Though there were others who would have agreed with 2907, who commented that

> "I have been doing behaviour therapy, group therapy and individual psychotherapy. I consider that our understanding of behaviour therapy is greater than the others, but not for group or individual therapy, by no means are we better at it".

It might be thought that there would be widespread support from the psychologists for the view that behaviour therapy be regarded as their unique contribution. Certainly, there were some who considered that "wards should be organised according to Token Economy principles" (2403) and that learning theory was offering an alternative conceptual framework to the medical model. But these were psychologists working in Oakdene Hospital, where the problems were somewhat different to those encountered within the mental hospitals. While several psychologists in the mental hospitals carried out behaviour therapy, most of them pointed to its limitations and how it "only works, if the sessions develop into psychotherapy" as 2501 noted. In fact the majority dissociated themselves from behaviourism as a theory, quite apart from its practice, and several would no doubt haveagreed with 2500 who observed that

> "If there were sufficient doctors we would be out of the treatment situation. Except that is for behaviour therapy, because the doctors are not interested in it, as it is too boring".

The final comment on behaviour therapy should go to the psychologist with the greatest training in it (1)

(1) She had trained at the Maudsley. However, this was only one episode in a very mixed career. Although still practising behaviour therapy she was gradually abandoning its precepts and in her terms "I am now regaining confidence in my own intuitive approach, after having it knocked out of me at the Maudsley".

> "I can see some value in the application of learning theory in the modification of habits and experiences. But to have any value its concepts must be expanded to include feelings and body sensations, hallucinations and spiritual experiences. But can we any longer say it is unique, there are doctors carrying out behaviour therapy, and behaviourally inclined social workers - so just what is our unique contribution?" (2901).

This rhetorical question that reflects the doubts many other psychologists expressed about their contribution, was made by one who was committed to her occupation. For others, particularly the dissidents, such doubts were inclining them towards leaving the occupation. As one of them said

> "I am rather disillusioned with clinical psychology at the moment, at least in the sense that our professional skills are of no use to anybody. As individuals one should be able to find ones niche within a therapeutic community without being held down by disciplinary frameworks" (2503).

In fact, as the analysis of the 'professionals' showed, the majority of psychologists were committed to their occupation and had faith in its future value, even if they felt it was not considered very relevant at present. However, even those who believed they understood more about certain forms of therapy, often invalidated or undermined such claims by relating actual ability as a therapist to 'personality'. A good example of this being provided by 2500 "Successful psychotherapy depends upon the personality of the therapist rather than upon the school that he belongs to or the techniques that he uses".

It would be erroneous to convey the impression that there were no psychologists making 'grand' claims for their profession, there were some who would have agreed with 2401, who claimed that "even by present standards of training and knowledge, we are in a better position to set up treatment procedures and control for different circumstances, than are the doctors. Our training at least equipps us to think critically". But the majority were more moderate and circumspect in stressing the limitations of their own contribution, its lack of relevance, or how it could be made by someone else.

The division of labour - a natural order?

During the interviews, everyone was asked 'how far is there a natural division of labour between the different professions that work within psychiatry?' The purpose of this question was to find out how far the subjects themselves felt their work overlapped. Table 24 below was constructed out of the replies, among which there appeared to be four main categories of response. Many of those who appear in the 'clear at centre' column could have appeared in the 'clear cut/natural' column and, likewise, those in column three could have appeared in four. The differences being largely a question of emphasis, as the quotations given below demonstrate.

Table 24: The division of labour

	1 Clear cut Natural	2 Clear at Centre	3 Clear at Edges	4 Complete overlap	5 Unnatural
Ps	10 (26.3%)	16 (42.1%)	11 (28.9%)	1 (2.6%)	-
SW	10 (26.3%)	15 (29.5%)	9 (23.7%)	1 (2.6%)	3 (7.9%)
Cp	2 (7.4%)	9 (33.3%)	10 (37.0%)	4 (14.8%)	2 (7.4%)

When columns one and two are combined the percentages seeing a 'fairly' natural division of labour becomes, 66.4% for the psychiatrists, 55.8% for the social workers and 40.7% for the psychologists. When columns three and four are combined, the figures become 31.5%, 46.3% and 51.8% respectively. These figures serve to substantiate points that have been made earlier on (particularly in Chapter 7) about the way the medical profession believes that there is, or rather should be, a division of labour that has been decided by themselves. This was particularly the case with the 'doctor'

psychiatrists, as one of them commented

> "I am clear in practice as to what I do, and what I would like the social workers and psychologists to be doing in any one case. When you are dealing with other people you must define clear areas of operation between the three groups" (1508).

Another commented that 'in a good team the identities are not at all blurred' (1601), while another said "there is a clear division of labour, if properly applied" (1521) (1). Likewise the welfare workers made such comments as "we all know our roles" (3400) or as another stressed "There should be a division of labour, there must be, as you look at it from different aspects. I think there is a natural division at the moment that has worked fairly well" (3211). However, as the table shows, the majority of staff considered there was some degree of overlap, although they disagreed as to the extent of it.

Those that found the overlap to be at the edges, appeared to consider their core activities to be distinct, in which case the overlap occurred over, in their terms, peripheral activities such as 'attending ward meetings', 'taking group therapy',,'having supportive relationships with patients', some considered the treatment of the neuroses to be an area of overlap, while several simply referred to there being confusion over who does 'therapy'. However, it was among those staff who were seeking to dissociate themselves from the restricted view of their role, that the perception of 'considerable overlap' was clearest. Such staff put their

(1) Several of the 'doctors' made critical comments on the 'failure' of the therapeutic community approach in this respect, as 1602 noted "Obviously some blurring of roles is inevitable, but I still think that people have specialist roles, and if you blurr them too much you lose the invaluable specialist contribution. In our therapeutic community unit the blurring has gone too far, so that everyone carries out minor psychotherapy, to the expense in social work, of the more mundane, practical and often more beneficial things".

'testing', 'welfare', 'interviewing', 'prescribing' and generally routine work at the periphery, with the consequence that there was inevitably overlap, or 'confusion' as some would have it, over who could or should carry out 'therapy'. Such staff were often primarily interested in being therapists and often recognised, as one eclectic psychiatrist noted

> "We overlap in the understanding of the psychodynamics, the interpersonal, emotional and environmental stresses on the patient, and over our ability to act as a therapeutic agent with the patient" (1510)

Many of these staff who were often 'eclectics', 'therapists' or 'professionals' appeared to believe that anybody could carry out psychotherapy, and thus there were such comments as "everyone within this hospital seems to be mucking in with psychotherapy" (2601) or, as 3506 observed "There is a large area of overlap, when it does not matter who does the work, such as the taking of groups and doing individual work with patients. This is at the centre of everyone's work, while we differ over the less important things". The most frequently mentioned area over which there was overlap was that of 'psychotherapy' or merely 'therapy', but as became apparent in replies to a specific question about psychotherapy, there was little agreement as to what psychotherapy was. Before considering this question, it should be noted that those staff who felt there was a 'complete blurring of roles', often appeared to suggest that was how it <u>should</u> be, rather than how it actually was. It was observed in the analysis of the dissidents that they were the staff who were most committed to break down the existing divisions between the disciplines.

Quite apart from the information that this question of the division of labour gives in identifying how much overlap there was between the work of the three groups, it also suggests that there is a problem of talking about the social structure of the treatment settings without reference to the way the participants perceive relationships and each others' role.

The varied way in which staff working alongside one another perceived the division of labour between themselves, suggests that it would be difficult to arrive at an 'objective' description of the situation. At the same time time it is important to note that it was the psychologists who were the group that was claiming its work overlapped with the others the most, whereas the psychiatrists were taking the most exclusive view of their own skills. Certain consequences of these differences can be seen, when the question of who carries out psychotherapy is considered.

Psychotherapy - what it is, and who can carry it out

The term 'psychotherapy' has long been recognised as being a word over which there is little agreement as to what it means. It has also been identified in various American studies as being the area over which there is the greatest conflict between the psychiatric professions. In Chapter 2 reference was made to these studies and also to that of Henry et al (1971) in which it was suggested that as the four main psychiatric professions carry out psychotherapy, then a 'fifth profession' of psychotherapists should be created out of an amalgamation of these occupations. This suggestion has come largely from the United States, where arguably the influence of psychoanalysis and its various derivative forms has been greatest. However, there are also signs of increasing concern in the UK over the practice of psychotherapy and there has been talk of establishing a register of 'qualified' psychotherapists (1). The problem is, of course,

(1) A recent article in the Guardian (6 May, 1974) has drawn attention to these moves that follow the Foster Report. In the same article attention is drawn to the lack of provision for psychotherapy in the National Health Services.

that even if certain practices were identified as being 'psychotherapeutic', then how would control be established over their application. The lack of agreement as to what constitutes psychotherapy, and further, the conflicting views over the necessity of training (and of even undergoing psychoanalysis as part of the training) have been referred to already in the earlier chapters. Unfortunately the material that was collected in the interviews on this subject, was not as detailed as it might have been. Some general points can, however, be made about the question and, the bearing that it has upon the question of psychiatric 'expertise', and the existing structure of staff relationships.

It has already been noted how many staff, especially those holding the 'centre' ideology, pointed out how they carried out psychotherapy. The table below gives an indication of the differences between the occupations over this.

Table 25: The number of staff claiming to carry out 'psychotherapy'

	Practiced psychotherapy	Mixed responses	Did not practice psychotherapy
Ps	26 (68.4%)	4 (10.5%)	8 (21.1%)
Cp	20 (74.0%)	0 -	7 (25.9%)
SW	22 (57.9%)	7 (18.4%)	8 (21.1%)

These figures must be regarded as being only a very crude indication as they say nothing of the meaning given to the term psychotherapy. For example, many of those in the 'mixed' category distinguished between 'psychotherapy' and 'therapeutic relationships' and considered that they carried out the latter, although at times it might be like the former. Significantly, those staff who denied carrying out 'psychotherapy' were often 'doctors', 'welfare workers' and 'testers'. Various examples of the

way psychotherapy was defined are given below as illustrating the problem of identifying how far it was regarded as being an activity that required specialist training. Table 25 above shows that the psychologists divided more clearly than either of the other groups overthis question, thereby demonstrating their greater awareness of psychotherapy as a distinct approach to therapy, to be conducted along certain lines. In contrast the psychiatrists often gave the most general definitions, although more of them referred to the difference between 'depth' and 'supportive' psychotherapy, than was the case among the social workers.

Psychotherapy was described as being anything from "depth psychoanalysis to ECT" by one psychiatrist (1608). While few other staff would include ECT, there were several psychologists carrying out behaviour therapy, who likened it to psychotherapy (1). As might be expected those staff who had undergone psychoanalysis, and or training as psychotherapists tended to define it according to certain principles, such as

> "psychotherapy is a specialised relationship, an artificial relationship that must be centred around the transference situation. Other types of relationship can be therapeutic - but these are not psychotherapeutic as such" (1507).

Other such staff also talked of the 'transference' situation, or the "conducting of the relationship according to certain dynamic principles" (1518), that might involve "exploring elements of the patient's unconscious" (2903). In general such staff saw psychotherapy to be more than "simply relating and talking to patients" (3500), and they usually stressed the need for some form of training.

This more specialist view contrasted with what was the predominant view of seeing psychotherapy to be "talking treatment" (1603), or as "relating

(1) In particular, 2501 stressed how behaviour therapy would not work unless a therapeutic relationship was established between the therapist and the patient.

with patients" (3205) in either an "active" manner (2500) or more passively. Often it was equated with being "supportive and generally sympathetic towards the patients" (3607) and with having "caring relationships" (1508), in which "insight into the patients problems" (1516) and generally 'interpretation' is given to the patient. Some distinguished psychotherapy as being relationship in which certain "goals were specified" (3208) and which there was an intention to "help the patient, change themselves" (2800) through helping the "patient come to terms with themselves" (2901), which for several social workers could be done through a variety of "individual, group and community methods" (3504, 3511). Many such staff, observed that 'all relationships could be therapeutic' and that they varied according to the 'intensity' or 'depth' or purpose. For one psychiatrist psychotherapy could be distinguished from other relationships if the patient was "seen regularly at certain intervals, the intensity of the relationship does not make the difference" (1605). Somewhat similarly to those staff who talked of 'supportive' relationships being a form of psychotherapy, there were a few who referred to 'counselling' as being like psychotherapy. This distinction was made several times by psychologists, while several social workers likened casework to psychotherapy (1). These short quotations have been given so as to illustrate the range of views expressed, and to point to the general problem of identifying the meaning given to claims to practice psychotherapy.

More important than this problem of definition, are the practical

(1) Perhaps the strangest definition of psychotherapy came from a psychiatrist at Oakdene who talked of psychotherapy being "a matter of explaining to the old the different outlook of the younger generation, and vice versa. The trouble is that they old don't understand the young, and the psychiatrist has a special role in explaining the problem" (1406).

consequences of the psychiatrists' belief that not only could they practice psychotherapy themselves if they so wished,but that they could also decide when it was necessary, and also supervise either junior doctors or the other staff, when they carried it out. Although the psychiatrists differed among themselves over this, as was pointed out in Chapters 6 and 7, many assumed this to be part of their mandate, even if, as is noted in the next chapter, they did not supervise the other staff very closely. In the analysis of the 'doctors', it was noted that such psychiatrists frequently wished to limit the lay staff to certain activities, among which they did not include psychotherapy. Some lay staff themselves did not want to carry it out either, indeed a few of the welfare workers were critical of their colleagues for getting "too involved" over this. Bearing in mind the assumption of the psychiatrists and many of the other staff to be 'qualified' to carry out psychotherapy, it is worth considering the extent to which they had been, or were currently being trained to carry out various forms of therapy. The figures given below are taken from information given in the short questionnaire, that was filled in by the subjects themselves [illegible]. The first table refers to the extent to which the respondents believed themselves to be trained at certain types of therapy, while the second refers to those who were currently attending training courses.

Table 26: The number of staff who claimed to be 'trained' at therapy

	No	Psycho-Therapy (2)	*	Group Therapy	Beh. Therapy	Other (1)	N/R
Ps	18 (47.8%)	6 (15.8%)	2 (5.3%)	4 (10.5%)	1 (2.6%)	3 (7.9%)	4(10.5%)
Cp	3 (11.1%)	2 (7.4%)	1 (2.6%)	9 (33.3%)	4 (14.8%)	5 (18.4%)	-
SW	25 (65.8%)	3 (7.9%)	6 (15.8%)	4 (10.5%)	0 -	5 (13.2%)	-

Table 27: The number of staff undergoing training to carry out therapy

	No	Psycho-Therapy (2)	*	Group Therapy	Beh. Therapy	Other (1)	N/R
Ps	23 (60.5%)	7 (18.4%)	4 (10.5%)	1 (2.6%)	1 (2.6%)	1 (2.6%)	1(2.6%)
Cp	10 (37.0%)	1 (3.7%)	2 (7.4%)	5 (18.5%)	4 (14.8%)	5 (13.2%)	-
SW	16 (42.1%)	0 -	-	3 (7.9%)	0 -	3 (7.9%)	16(42.1)

These tables serve to illustrate certain points that have already been made about the varied levels of qualifications among the three occupations. The social workers appear as being the 'least' qualified in their own terms, to carry out 'therapy', only 34.2% of them claimed to be qualified, compared with 42.1% of the psychiatrists and 88.8% of the psychologists. Similarly, when the second question is considered, only 15.8% said they were currently undergoing training, compared with 36.8% of the psychiatrists and 62.9% of the psychologists. It should be emphasised that these figures should be treated with a certain amount of caution (3), but at the same time, they

(1) This could include the 'therapeutic community', 'community work', 'psychodrama'.

(2) This included those who mentioned psychoanalysis.

* This column comprises those who mentioned both psychotherapy and group therapy.

(3) In particular the possible ambiguity of the question over the meaning of 'therapy' and of 'qualification' should be noted. Such problems raise the general methodological question of the value of such fixed choice questionnaires.

add confirmation to the view that the psychologists are more 'qualified' at various forms of psychotherapy, and especially group therapy, than the psychiatrists.

The significance of this finding can be show by referring back to the lack of recognition granted to the psychologists, by the psychiatrists, for anything other than assessment and sometimes research. The psychologists themselves were usually quite conscious of this lack of recognition. How they sought to resolve certain dilemmas that it posed for them,, will be considered in the next chapter on the social structural position of the lay staff.

Personal qualities

In Chapter 6 it was noted that the 'doctor' psychiatrists valued certain qualities of 'stability', 'detachment' and 'neutrality' in the personalities of all staff working with psychiatric patients. Similarly, the other ideological types valued other qualities. In Chapter 6 the aim was to show how the qualities that were valued, differed between the various types. However, in the present context the repeated references to the 'importance of personality' or the 'kind of person you are', that were made when talking about ability as a therapist, can be seen to have an added significance. In Chapter 7, it was noted how the psychiatrists often detracted from the value of certain lay staff's contributions by attibuting their success to their personalities. In their turn, the lay staff often observed how the psychiatrists' abilities and orientation varied according to their 'personality'. Among the 'professional' psychologists and the more psychologically aware staff in general, there were frequent references to the conflicts between staff being due to 'interpersonal difficulties' and

'personality clashes' (1). In Chapter 6 it was suggested that such explanations were important elements in the ideologies of the 'eclectics', 'professionals' and 'therapists'. In this respect the 'dissidents' differed from the other staff, in so far as they were more likely to see conflicts arising from certain differences in ideas or power. However, the dissidents were often critical of formal training and qualifications as being irrelevant to the task at hand. In this way they also tended to personalise the carrying out of therapy. This was especially the case among those dissidents, and to a lesser extent those eclectics, etc. who stressed the importance of 'getting involved' with the patient, and 'relating to them as individuals' and so on. Bearing in mind the large numbers of staff who stressed the importance of relating to patients, and of the general role of using ones personality in a therapeutic manner, it is relevant to consider how many members of the different occupations had considered, or were currently undergoing some form of psychoanalysis. Table 28 below gives an indication of the differences between the three occupations, with the psychologists appearing the most favourably disposed towards the idea of undergoing analysis.

(1) This was especially the case at Oakdene where some of the staff were accusing the others of suffering from various forms of mental illness.

Table 28: Attitudes towards undergoing psychoanalysis

	No (1)	Maybe (2)	Yes (3)
Ps	22 (57.9%)	10 (26.3%)	6 (15.8%)
Cp	6 (22.2%)	10 (37.0%)	6 (22.2%)
SW	22 (57.9%)	5 (13.2%)	11 (28.9%)

It was observed in Chapter 6 that a feature of the 'doctor' and 'welfare worker' mode of response was the rejection of the idea of undergoing analysis, and the almost hostile attitude towards some of their colleagues who had done so. The large numbers of psychiatrists and social workers in the 'no' column can be accounted for by this tendency among these sections of their membership. If it is accepted that it is relevant for staff working with psychiatric patients to undergo some form of therapy themselves, so that they may be more effective therapists with their own patients, then the social workers would currently appear to be the most and the least 'qualified' in this respect.

Henry et al (1971) have based their claims for the development of a 'fifth profession' on their evidence that all the psychiatric professions carry out psychotherapy and all of them undergo similar forms of training. The evidence from this study might confirm the first of these propositions,

(1) This included both 'no' in the past and 'no' in the present.

(2) This includes those who said 'they were thinking about', or 'If I can get a grant', or 'if free', etc.

(3) These tended to either have undergone analysis, to be undergoing it, or to be definitely intending doing so. The 'depth' of the analysis varied from a few, doing the full five days a week analysis, to others attending group analysis sessions. The high figure among the social workers can be accounted for largely by the local authority social workers, several of whom were undergoing Jungian analysis.

if a very broad and loose definition of psychotherapy is taken, but it would certainly go against the second, if the evidence of the general lack of training (see Table 26) is at all typical of the situation among other members of these occupations. It is not, however, the aim of this study to adjudicate between the various claims being made, but rather to analyse them for what they are. That is, to see them as expressions of claims that become part of the ideologies that surround all occupations in their attempts to preserve their mandates.

That having been said, the question remains of what significance to attach to the repeated references to the importance of 'personality'. At one level, such assertions would appear to relativise all the various claims, to have abilities that derived from training and formalised knowledge. If this is accepted then the occupationally dominant position of the psychiatrists appears even more remarkable. At another level, however, it would appear that the practice of psychotherapy, and the consequent importance of personality, is only considered relevant with certain categories of patients. But as these categories of patients are the very ones that all three occupations claim to be able to treat, then the question of having the 'right' personality becomes of central importance again. All that can be said is that the importance attached to personality appears to reflect the generally acknowledged lack of effective therapies and more importantly in this context, the lack of agreed criteria as to who are, and who are not, 'good' therapists.

Conclusions

In order to appreciate the significance of the material presented in this chapter, it is necessary to refer back to points raised in earlier

chapters. In Chapter 4 it was suggested that some indications as to the present problems facing all three occupations could be found by a study of their origins and development. It was pointed out in that chapter that all three occupations contained within them divergent tendencies and conflicts of approach. The ideological types that emerged from this study and outlined in Chapter 6 illustrate the contemporary reality of such differences. A recurrent theme both in the analysis of these types and in the following chapters has been the attempt to identify how far each occupation, can be regarded as possessing certain skills, knowledge and abilities that are distinct to that occupation. The problem has been that the members of these occupations differ among themselves as to the nature of the claims they make for their expertise. That is they may agree that certain tasks are theirs, and no one elses, but they then disagree as to what tasks ought to be theirs. Earlier studies (1) are also divided as to the extent of agreement over the division of labour among mental health professionals. Perhaps the most significant finding of this study in this area, is the discovery that there are both large areas of agreement among the staff as to who should do what, and also important areas of disagreement.

In Chapter 8 it was noted how the majority of the lay staff accept the necessity for physical treatments, and that these should be in the hands of the psychiatrists. When the psychiatrists' views of the lay staff were

(1) Schatzman and Bucher (1964) found so little agreement among the psychiatric professionals in their study that they suggest that any attempt at role analysis was futile as there was no stability within any of the teams they encountered. S. Lee Spray (1968) on the other hand in a study of 735 psychiatric professionals found that whereas the psychiatrists and psychologists claim therapy to be their major job activity, administration appears to be that of the social workers and teaching and research that of the psychologists. He concludes that "Little actual role blurring has occurred in the functions performed by the mental health professionals" (p.59).

analysed in Chapter 7, it was noted how they recognised the skills of the psychologists at assessment work and of the social workers at various welfare activities. Whether or not any of these groups considered one another relevant for the patients is another question. All the groups concerned appeared to accept with varying degrees of accord or reluctance that it was necessary and proper for themselves to carry out these 'routine' activities. Clearly as Chapter 6 demonstrated, there were large sections within these occupations that invested this 'routine' work with considerable significance. For such staff there was hardly a problem of 'role blurring' or 'overlap' as their spheres of activity rarely crossed. However at the same time, there were many other staff, as Table 24 on page 266 demonstrates who felt there was 'considerable' overlap, especially over the area of therapy or psychotherapy. This question will be returned to in a moment, but first it is necessary to draw attention to the significance of the considerable agreement that appeared to exist between the staff.

Such agreement can be shown to exist by referring to the way very few of the lay staff, for example, made any reference to members of their respective occupations being involved in the process of deciding on admissions (1), making the initial assessment of patients, deciding their diagnosis (though some psychologists mentioned this), taking part in various leadership functions, and in general terms making certain policy or management decisions (though some saw themselves as playing an advisory role in these matters). Similarly, the psychiatrists did not talk about arranging hostel places for patients, interviewing the relatives, or administering certain forms of psychological assessment. Various

(1) Though some local authority social workers were involved in the admission process from outside the hospitals.

qualifications could be made to all these assertions, but the general point still stands. Often in a negative way, of defining themselves out of certain activities, the staff who were interviewed, suggested that there was a large area of consensus as to who did what. Further many indicated that they had no wish to take over certain activities carried out by the other staff. This was particularly the case among many of the therapist-social workers and professional-psychologists, who often specifically talked of not wanting to take over some of the tasks performed by the psychiatrists. As might be expected, those staff who gave the clearest exposition of their own tasks and those of the other staff, conveyed the impression of having the fewest doubts about the value of their own, and the others contributions. This large area of consensus found to exist contrasts sharply with the impression conveyed by many of the earlier American studies. The problem of what interpretation to place on these studies has been considered in Chapter 3, and thus need not be discussed again. However, as noted in the earlier discussion, much of this conflict has revolved around the practice of psychotherapy.

Without repeating the varied ways in which the term 'psychotherapy' is defined and used, it can be asserted that there is considerable confusion as to its meaning, and to the sort of training that is required for those staff who carry it out. While some training institutes may define it in a particular way and claim that only trained staff should be called 'psychotherapists', they can neither claim a monopoly over this title, nor the practice of this activity. Not surprisingly the clearest area of overlap among the staff was over the carrying out of 'psychotherapy'. Many expressed neither surprise nor resentment that this should be the case, and took this to be a normal and even desirable state of affairs. However, among those staff who considered themselves in some way qualified to carry out psychotherapy, there was often considerable resentment at

the way they felt they were not recognised as possessing these skills, or were unable to use them effectively, or had them devalued through the suggestion that 'anyone' can carry it out. Some such staff expressed a desire for a register of psychotherapists (1), although others did not wish to appear restrictive.

Throughout the previous chapters and in this one, there have been frequent references to the way many of the lay staff, considered the medical model and psychiatric approach to treatment, to be unnecessarily narrow in scope and negative in its consequences. For many such staff, a more humane and effective approach to treatment would be more psychotherapy, or in the case of the psychologists at Oakdene, the application of a social-learning/education model. Many psychiatrists would themselves accept the limitations of their present approach, and might agree that more psychotherapy or behaviour therapy were necessary. Whether or not psychotherapy can be seen as being the answer, the problem remains of accounting for the apparent conservatism among all the occupations concerned. This conservatism can be shown, not so much by any apparent resistence towards 'psychotherapy' or other new techniques, but rather in the daily affirmation and maintenance of a social structure that reflects the interests of certain groups that are unwilling to relinquish their control and domination. The next chapter will be concerned with examining the nature of this social structure as experienced by the lay staff, and further with attempting to explain certain contradictions in their position, and the conservatism of the senior staff within these occupations.

(1) The Foster Report (1971) expressed concern about the uncontrolled practice of psychotherapy, and suggested the setting up of a register. The psychologists appeared to have been the first of the occupations most affected by this recommendation, to set up a committee to investigate this question and make recommendations. A few of the psychologists interviewed for this study pointed out that as psychologists were the most qualified to carry out psychotherapy, they should be the ones to decide on the nature of the qualifications needed to be on such a register.

CHAPTER 10

THE SOCIAL STRUCTURAL POSITION OF THE SOCIAL WORKERS AND PSYCHOLOGISTS AND THEIR SENSE OF PROFESSIONAL IDENTITY

Summary: This chapter is concerned primarily with what has been termed the social structural position of the lay professions. Through an analysis of the way the members of these occupations perceive the structure of the relationships in which they work, there is an attempt to situate the question of professionalisation within this structure. Related to this task is the need to consider the extent to which the members of the two occupations were actually seeking to professionalise their occupations. This chapter will also consider such questions as the problems of gaining access to patients, and the freedom of the staff to do what they liked with patients, and various attitudes expressed by the social workers and psychologists towards their professional associations. The general question of resorting to collective action is also considered as having a bearing on the likely way in which these groups may change their social structural situations.

Introduction

This chapter is initially concerned with the difficult task of reconciling what are taken to be certain 'objective' features of the social structure of the treatment settings, with the 'subjective' views of these features as held by the staff who were interviewed. In one sense this is a problem of consciousness, for the central question is very much one of seeking to establish how far the staff considered themselves to have autonomy and 'freedom' over their own actions. In the second part of this

chapter the question of consciousness is explored in a different direction. This time the problem is the extent to which members of the lay occupations had a sense of having a distinct 'professional identity'. The different attitudes that were expressed towards the whole question of professionalism are then taken as illustrating certain contradictions that have appeared in the earlier section and in previous chapters.

In Chapter 2 various criticisms were levelled against those theories of professionalisation, that fail to take account of the social structural position of the occupation being studied. Indeed it was argued that one of the weaknesses of many of these studies was their concentration on single occupations as if they existed in a social vacuum. It was observed that most occupations face rivals of various sorts, and some find that they are only able to pursue their own tasks in institutional contexts in which there is an already established and powerful profession. Freidson, in particular, has drawn attention to the peculiarly powerful position of the medical profession, and has further argued that it is having autonomy over ones actions, as he claims that medical profession has, that makes a 'genuine' profession. Freidson's case is a very strong one, even if objection is made to his attempt to find a single criteria with which to distinguish professionals from the non-professionals. However, certain criticisms have been levelled against this view of the medical profession being 'all powerful'. From ethnomethodology there have been a series of studies that have demonstrated how doctors have to 'work' at maintaining their autonomy, through the use of various 'routines', 'strategies', and a daily ordering of the various 'emergencies' that face them in order to preserve their autonomy, in the face of possible threats to it from patients, relatives of patients, and other staff (1).

(1) Bloor, M. (1974), West, P. (1974)

From a different theoretical perspective, namely symbolic interactionism, other points of criticism have emerged. In a collection of publications, a group of American sociologists, working both collectively and individually, have produced a series of studies on various professions, working in medical and related contexts (1). In a paper that draws together what they take to be the implications of much of this earlier work, Bucher and Stelling (1969), have argued that the social structure of the work situation of professionals in organisations such as mental hospitals, is one in which there is continuous negotiation and re-negotiation. They argue that in such work locales there is no pre-existing role structure "Rather the new member builds his own place in the organisation and creates the role he plays there" (p.5). Further, than that, "Role creation is a direct consequence of being accorded professional status. The professional is the person who has the right to say what should be done and what is necessary to get it done" (p.5). Other points flow from these assertions, 'professionals' seek to control their 'work space' as their 'self esteem, reputation and career' is at stake. Having outlined the various forms that 'negotiation' takes at the individual level, Bucher and Stelling consider it at the collective level. They note how there is a 'continually unfolding internal differentiation or segmentalisation within the organisation' (p.7). They liken this process to a political one, involving negotiation, bargaining and the formation and dissolution of alliances. The consequence being that

> "The power to determine policy is not clearly located in specific

(1) Strauss et al (1964), Strauss (1963), Schatzman and Bucher (1964), Bucher and Strauss (1961), Schatzman and Strauss (1963), Bucher and Stelling (1969, 1970), Bucher (1969), Ehrlich and Sabshin (1964).

positions. It is more diffuse, and the locus and balance of power often shifts in response to different issues, and as different groups and persons move through the organisation" (p.11).

In Chapter 3 certain qualifications were made about the value of comparing the American literature on the psychiatric professions, and these points need not be repeated here, except to say that the evidence of direct confrontation, negotiation and argument observed for example by Schatzman and Bucher (1964) may to a large extent be culture bound. At the same time Bucher and Stelling have made an important point in drawing attention to the complexity of this question and the danger of simply reducing the issue to authority relations between professionals to a zero sum formulation.

The problem remains, however, of how to explain the structure of professional relationships within organisations that are largely controlled by the professionals themselves. It might appear that Weber's (1964) three types of authority are all relevant to explain the dominant position of the psychiatrists, as they combine all three types, having legal authority from the Mental Health Act, rational authority from their expertise, and traditional authority for the cultural expectations surrounding the role of doctor. However, on all three counts this authority has been challenged, particularly within psychiatry, and besides it does not explain professional relations, as well as it does relations with patients. There are other models and typologies of organisations (1). But it would not appear that 'coercive' models of control are appropriate when applied to

(1) See in particular Etzioni (1961), where he distinguishes between organisations that win the compliance of their members through various combinations of the following sanctions; coercion, remuneration, normative, such that they induce three kinds of involvement. Respectively; alienated, calculative and moral. Also worth noting is the work of Gouldner (1955), but again his typology is more relevant to industrial settings than hospitals.

an understanding of relationships between professionals. That is to say, it may well be that in 'reality' certain professional groups either have a coercive role as arms of the State, or can coerce their colleagues into compliance by the use of certain sanctions. For example, in the context of psychiatry, the medical profession can stop other staff from doing things with 'their' patients. However, it would appear from the attitudes expressed by the psychiatrists (analysed in Chapters 6 and 7) that most of them, even the 'doctors' who expected to 'direct their assistants', also sought to win their moral involvement. Other psychiatrists saw the question to be one of 'team work' and 'cooperation', and it was a feature of the eclectic ideology that they believed themselves to be 'non directive' and 'non restrictive' towards the other staff.

There is thus a need, on the one hand, to consider the question of autonomy as a key in any discussion of professionalisation, while on the other, there is a need to consider the possibility that mental hospitals are 'arenas' in which there are shifting balances of power. The question then becomes one of how to account for the 'objective' differences in power, that can be observed to structure relationships, with the 'subjective' awareness and denials of such differences. In other words, the question becomes one of the nature of consciousness. The initial outline of the various ideological types in Chapter 6 attempted to demonstrate the different levels of 'consciousness' among the various staff through an examination of the way they defined various aspects of their situations. An important element in such definitions being their perception of the authority structure and the degree of legitimacy they accorded it. The first part of this chapter is concerned with examining certain features of these perceptions in more detail, in order to examine the nature of the autonomy enjoyed by, or denied to, the lay staff. Unlike Bucher and Stelling (1969) who appear to claim that power cannot be identified and

located, it is believed that the medical profession is still in a structurally dominant position in British mental hospitals. While, in contrast to Freidson (1970) who appears to assert that staff either have complete autonomy or none at all, it is believed that it is very difficult to identify the nature of 'autonomy' without reference to the way staff themselves perceive the extent of their own freedom.

In the first part of this chapter, on the social structural position of the lay staff, there will be an initial consideration of the nature of the referral process, and how far the social workers and psychologists had problems in gaining access to the patients that interested them. The fact that psychiatrists are able to prevent lay staff from having access to certain patients, through various direct and indirect methods, is being regarded as an example of their 'objective' power. However, the extent to which this power was seen as restrictive and limiting will depend on the sort of contact that the lay staff wish to have with the patients. Hence the need toconsider the points made in the previous chapter and Chapter 6 about the limited claims being made by many lay staff. After considering the problems of access to patients, the lay staff's awareness of direction and supervision will be considered.

In the second part of this chapter issue will again be taken with Bucher and Stelling. An important element in their theory about the nature of 'professional organisations' is the assumption that professionals have a clear sense of their own mandate, mission and identity. Much of the confrontation that they observed would appear to stem from the various professions sensitivity to having their 'work space' encroached upon. It has already been observed in Chapter 6, that a feature of the dissident ideology and also the welfare workers was their opposition to the various attempts being made to professionalise their occupations. In the second

part of the chapter this question will be explored in more detail, in order to draw attention to the contrasting positions, not so much between the ideological groups within the lay professions, as between the two occupations. Certain points of contrast between the psychiatrists and the lay staff in their attitudes towards their professional associations will also be considered. When this question is extended to include an examination of how far the different occupations would resort to collective action, either for their own ends or those of other people, certain fundamental differences in outlook can be identified. It is believed that such differences have a bearing on the initial question that was posed at the outset of this chapter, namely the nature of the 'consciousness' among psychiatric occupations.

Part 1: The social structural position of the lay staff

In the study by Rushings (1964) the social workers, and to a lesser extent, the psychologists, found gaining access to patients to be one of their major problems. Clearly the basis on which staff gain access to patients not only largely defines what they are able to do with patients, but also decides the extent to which their performance is judged by others staff. Freidson (1971) has drawn attention to the way that specialists who are dependent on other staff for referrals must be mindful of the criteria of performance of their referring colleagues, if they are to ensure a supply of patients (1). As referral processes can be considered as providing

(1) This problem can, of course, be reversed, when the specialist receiving the referrals is getting more than he can cope with. See Robinson (1974) for an analysis of the strategies used by consultants in an alcoholism unit to resist referrals.

at least an outline, of the structure of the relationships between the medical and lay occupations, they will be dealt with first. After that, the more 'subjective' aspect of the staff's awareness of the social structure will be considered.

Referrals to the social workers and psychologists and their problems of gaining access to patients

Perhaps as a reflection of the greater acceptance of the social workers by the psychiatrists, that was noted in Chapter 7, only a few social workers reported any problems in gaining access to patients (1). With the possible exception of the two working in Oakdene Hospital, all the other hospital social workers noted how their involvement 'as members of the team' gave them direct access to any of the patients on their units (2). The situation of the psychologists was less clear cut, as it was only at Wheatbury and Willows Hospitals that they were attached to certain teams. Even in these hospitals the psychologists also received referrals in the traditional manner, while the remainder were in the position of one psychologist who commented

> "We do not get access to patients to see them for ourselves, but only when they are sent to us by the doctor. I am not in a position to pick out patients for therapy, except as a by product of a referral" (2505).

(1) The position of the local authority social workers of course was different to that of those who worked in the hospitals. Many mentioned the varied sources of referral that they received, not only from GP's, hospitals, and other medical sources, but also other social work departments, teachers, self referrals, etc. Some did, however, attend ward rounds at Ashbury Hospital in order to pick up referrals from the doctors there.

(2) At Oakdene Hospital the social workers attended various meetings at which patients were referred to them as well as by a variety of other staff, not only the medical.

Other psychologists, however, stressed how they had a 'free hand' in being able to see whatever patients interested them. The significance of this question of access, when considering the nature of the autonomy of the lay staff becomes apparent in a comment from one of the principal psychologists that "The doctors can stop us doing things, they control who comes here, we cannot demand to see patients - but that's about all - they can limit us in that way" (2500). In this way, this psychologist and others like him were aware that the psychiatrists had certain rights that were denied to themselves.

It has been argued in Chapter 7 that the various welfare tasks carried out by social workers, have made them essential for the smooth running of most admission units in psychiatric hospitals. The same can of course be said for social workers in local authorities. This may account for the readier access that they had to patients, than that enjoyed by the psychologists. Certainly, many psychologists drew attention to their dependence on certain psychiatrists for 'interesting referrals', and in some cases for patients at all. The dependent position of such psychologists can be well illustrated by reference to one particular psychologist, who considered himself a qualified psychotherapist and yet who had no direct access to patients, except by referral from the psychiatrists. He pointed out how

> "I was receiving patients on a regular basis from a consultant who has just left. He trusted me and his leaving has been a great set back to me. I was taking both individual and group psychotherapy with his patients, but this has all stopped. This stems from the instability of the whole organisation. One day I feel that things are going very well and that I have a central role, but then the next day I find that the consultant or registrar have left, and so I have to start all over again" (2601).

This psychologist was in an admittedly difficult position, being virtually the only one in a sixteen hundred bed hospital, but he was not alone in finding himself in a situation where he had to depend on the favours of

certain psychiatrists to get access to patients that he felt he could help. Many of those psychologists who worked in situations where they had more direct access, also found that their contribution was affected, if not wholly determined, by the nature of the relationship that they enjoyed with certain consultants or other psychiatrists, within the teams of which they were members. As one such psychologist pointed out

> "I find that I have different relationships with different psychiatrists, there is one consultant who essentially takes all the decisions, her junior doctors refer to her constantly. She is very orthodox - stressing the organic all the time. All I do is just assess and offer ideas upon my assessment. One knows where one stands in this kind of set up. I know I would not be able to extend my role if I tried. Incontrast I have a very close working relationship with a junior doctor on another unit. I have a more consultative role here and I feel that I am offering something more important. We run a therapy group together and there is quite a lot of confusion over our roles in this" (2902).

The significance of this dependence on having 'good relations' with the consultants in particular, was not lost on one of the principal psychologists who observed how

> "On a personal level a psychologist can establish himself with a particular consultant. If he has confidence in you then he will let you do things, but if he has no confidence in you, then no matter how good you are, you have had it" (2500).

Throughout the interviews there were frequent references to this problem (1), and it should be noted that psychologists from all three ideological types drew attention to it in various ways. Such psychologists clearly felt that what they could do with patients depended very much on who the referring agent was. In contrast, very few social workers drew attention to this problem, although several mentioned how some psychiatrists were more directive and specific than others, when requesting that they do something.

(1) Another referred to one consultant who spoke in the following manner "Psychologists do this, present us with the facts, that's how you will help us, but I make the diagnosis as that is a clinical matter." But she went on to note how she worked with another doctor "who lets me do what I want" (2901).

The situation of the social workers was in many ways more complicated than that of the psychologists. They were expected to attend ward rounds, staff meetings and other occasions such as case conferences, when decisions affecting patients were made. Accepting that they were present, and thus able to become 'inside dopesters' in a way that was often denied the psychologists, the extent to which they still had patients referred to them remains far from clear (1). For example, many of the welfare workers conveyed the impression of knowing what was required of them and thus they would not wait for specific referral. Other social workers noted how they were 'requested to do things' or as one of them said

> "There is quite a lot of medical direction, since most of the things that I do are referred from ward rounds. But what I do after that is up to me. A doctor may suggest that I see a patient's husband, but they don't tell me what to say. It's hard to tell whether it's direction or cooperation - it doesn't feel like direction to me" (3601).

One of the therapist-social workers observed that "some social workers let themselves become the handmaidens of the doctors" and then pointed out that "I initiate referrals myself, this is where my approach is different, I suggest where social work is necessary, whereas many wait until it's asked for" (3511). However, the other social worker on the same unit as the above one, noted that "I am asked to do things, and they are expected to be done, but how and when is up to me" (3512). Many social workers drew attention to how they were able to ignore, re-interpret, or modify requests made to them by the doctors, or as one of them observed "It is a very easy to manipulate the situation here" (3507). This was especially the case where the social workers only saw the consultants infrequently, such as in the more traditional settings. The significant aspect of this information being, not

(1) Many ward rounds and other similar meetings were attended during the course of the field work, and the overall impression from these meetings was one of the social workers waiting to be asked to do things, although they often volunteered information, and sometimes made suggestions as to what they might do.

the varied ways of coping with referrals, but rather the choice of tactical means of resistance, thereby avoiding a direct confrontation with the psychiatrists.

Although some of the staff did make some reference to having certain problems in gaining access to particular types of patients, none saw the problem to be an insurmountable one (1). In contrast to the social workers of Rushings (1964) study who had the problem of routinising referrals to themselves, it was the psychologists in this study who had the greater problems. But even so, there were many references to having to discourage certain kinds of referrals, that were considered unnecessary and demeaning (2).

(1) There were references to such problems as gaining access to patients for research purposes by 2501, while at Oakdene the psychologists were denied access to the medical records. They in turn kept their own records on all the patients that they saw, and were similarly possessive over letting others see them. At Woodlands the psychologists had talked of approaching the medical staff to get permission to organise one of the rehabilitation wards along 'token economy' principles. They were anticipating difficulties over this, and likely opposition to their proposals.

(2) That this was a sensitive issue and one that affected the self regard and esteem many psychologists had for themselves was readily apparent. As with other issues, most of the psychologists related their difficulties to particular psychiatrists, and also to the turn over of medical staff. Hence the difficulty of institutionalising a desired relationship with a psychiatrist. The arrival of new junior doctors posed particular problems as they often made 'inappropriate' and 'trivial' referrals. When confronted with such referrals several strategies were open to the psychologists. The favourite seemed to be that of going over the head of the offending junior doctor, to complain to his consultant of his inappropriate request. In this way the psychologists were able to show up the junior doctor's lack of knowledge of psychology, while also affirming their own status of having direct access to the consultant, in such a way that avoided a direct confrontation with the junior doctor concerned. Although one of the 'testers' observed how she would "point out to the doctor how little they knew of psychology, otherwise they would have requested a more appropriate test" (2700). At two of the hospitals, the psychologists had introduced their own referral forms requiring the psychiatrists to state the nature of the problem,,without letting them specify the test to be used. In this way they were seeking to only accept referrals for assessment on their own terms. Interestingly, some psychologists objected more to the occasional referrals they received from social workers, than to those they received from the psychiatrists. Although others noted how they would like to receive referrals from a wider range of sources, and some looked to the creation of 'regional psychology centres' as being one means by which to make this possible.

The question of autonomy, however, cannot be left with the question of gaining access to patients, for as some of the quotations that have just been given suggest, there were members of staff who felt themselves to be 'directed' from time to time by the psychiatrists. That there was a certain amount of confusion was apparent from the comment of one social worker that "We have a lot of freedom, at least we do in some ways, but not in others" (3510). It should be emphasised that the majority of the lay staff felt themselves to have 'complete freedom' over how they organised their daily timetables, subject to the constraints of fitting in with other people's time tables (1). As one dissident social worker at Woodlands commented "We are very free as to how we spend our time here, a doctor may want a social history, but how and when one does it is up to us" (3504). This 'freedom' that is usually a characteristic of professional organisations can lead to a certain amount of mystification and can encourage the belief that one has autonomy over ones actions. This is especially the case in a therapeutic community and even more so when members of staff have limited and circumscribed conceptions of their own tasks and role. Bearing in mind the way many psychiatrists seek to be non directive in the relations with the ancillary staff, it is hardly surprising that there should be frequent observations, such as that made by one social worker that "There is direction, but no supervision over how you actually do the work" (3604).

(1) Several of the more junior members of staff noted how their own seniors put pressure on them to attend certain meetings. At Ashbury, the principal social worker always expected an explanation for any absence from a ward round. While at Wheatbury the psychologists were expected to attend as many meetings as possible, "so that we will be noticed, and in time people will begin to ask us to do things, and expect us to contribute, at least that is John's idea" (2906, John being the principal psychologist).

The lay staff's awareness of direction and supervision

As the final short quotation in the previous section demonstrates, many of the social workers drew a distinction between being directed as opposed to supervised (1). This distinction did not appear to be anywhere near so important for the psychologists, who rarely referred to there being direction over how they worked. What was more important for the psychologists was the nature of the relationship they had with particular psychiatrists, and the extent to which they 'limited' or 'restricted' their contribution. But at the same time, nearly all the lay staff were somewhat confused and contradictory in their view of the limits upon them. Some made such comments as

> "You just cannot generalise about this as so much depends on the individual, their personalities and interests, as well as the situation in which they work" (2900).

As noted in Chapter 6, in the analysis of the ideological types, an important element of the 'professional' ideology was the representation of their relationships with the psychiatrists, in terms that suggested they were not limited in what they did. It was argued that this ideology contained within it certain assumptions about 'working within realistic limits' and thereby having autonomy over what one does within those limits. In this way many psychologists, and also some social workers could assert there was no direction over them. At the same time, however, they were usually also very much aware of the fact that the psychiatrists

(1) Leaving aside the local authority social workers, 19 of the 24 hospital social workers denied there was any supervision over how they worked, though nearly all of them noted that there was direction.

had more power than themselves. Such lay staff tended to accept this as inevitable, and only complained about the excessive or arbitrary use of this power. Such awareness was shown by one psychologist who said

> "The fact of the doctors having legal responsibility does affect the kind of things that you can carry out. But I am happy to carry out those kinds of things, as I find them useful for the patients and moderately interesting. I quite like the work that I am doing so I think this is alright. I am very happy for them to have the legal responsibility" (2902) (1).

What is significant about this quotation is the way the fact of legal responsibility is introduced, for as another psychologist commented "You are continually being made aware that you are dealing with someone elses responsibility" (2905). Clearly, this legal responsibility cannot be 'negotiated' beyond a certain point, and it remains as a continual reminder to the lay staff of their inferior position. As was pointed out in Chapter 8, some lay staff believe that it is right that the psychiatrists should have this responsibility, but others saw no reason why they should not also share these responsibilities.

Thus, on the one hand, there was an overall affirmation by the majority of lay staff that they had considerable freedom. This was especially the case among those staff working in therapeutic community contexts, with their accents on 'communication' and 'participation', such that everyone is asked their opinion, while no one is told what to do. While, on the other, there was an awareness of being 'limited' or 'directed' or of 'feeling accountable' that many felt in various direct and indirect ways. Frequently this awareness amounted to a form of <u>self limitation</u>, that could arise from "being aware of a certain ethos, and not stepping outside of it" (2904), or from such experiences as recounted by a psychologist at Oakdene

(1) The sort of criticism that such staff were likely to make can be illustrated by reference to remarks from the same psychologist about a particular 'pig' of a psychiatrist, reported on p.313.

> "I am aware of some constraints, we have to make sure that the doctor agrees before taking up a particular course of treatment with a patient. Otherwise we are given a free hand. But being aware of particular difficulties, I don't take certain people on for therapy. Some of the treatment that we have given in the past has been sabotaged by the doctors and nurses, so now we really only do counselling work. We have a lot to offer, but we know it won't work in the present set up, so we don't bother trying" (2402) (1).

However, more typical were such comments as that of a therapist social worker "I am very free, although I do have to justify what I do to the doctors. This comes under the pretence of so called 'feedback', but it's not overpowering or restrictive" (3509). Sometimes such self-limitation took the form of not engaging in certain activities for fear of being rebuffed, as one social worker observed,

> "I am being very cautious about taking patients on for psychotherapy, although I have had experience of carrying it out in my previous local authority job. I am almost fearing the doctors disapproval, though for myself I don't think the limits are very tight" (3506).

This process of self limitation is somewhat similar to other tendencies noted among many of the lay staff, and observed for example in Chapters 8 and 9. In these earlier chapters the limitation took the form of holding a 'restricted' or 'narrow' view of ones own expertise and tasks. Through such processes a 'working consensus' is arrived at, over who should do what, with out any apparent bargaining or negotiation taking place. It is merely assumed by all the parties concerned that certain staff carry out certain activities. Clearly, disputes do arise, but what seems to be more remarkable is the reported accord or agreement that appears to exist.

Several of the senior members of these occupations appeared almost indignant at the idea of their being directed by the medical profession. As the principal at Oakdene remarked "I would bridle at any attempts to

(1) Or, for example, there was another psychologist who reported how she had been taken off work with drug addicts as "the consultant thought that it would be more appropriate for a doctor to do this work" (2905).

supervise us", although there were others such as 2500 who noted that

> "There is no doubt that there is medical supervision - but then they don't supervise us really. We would not accept it. I am not really aware of it except for the limitations" (2500) (1).

Quite apart from those lay staff who were aware of the 'limitations', there were others who drew attention to the 'hidden' pressures. As one social worker commented "It's all hidden pressure, it's only when you don't do something over a long period that you then find the pressure". Significantly, it was the dissidents who most frequently drew attention to such pressure, for it was they who most often transgressed the assumptions about the limits of their appropriate contribution. One such social worker, for example, reported having

> "been in trouble with the principal for having become 'too involved' with a family, as it was euphemistically put. All I had tried to do was to relate to them, in a meaningful way, what I saw to be happening to the patient here in the hospital. It seems that we can go and chat with the relatives, be supportive, and assure them that all's well with the patient, but we cannot go beyond that" (3504) (2).

It was noted in the analysis of the dissidents that they were much more conscious of the power differences between themselves and the psychiatrists and gave much more open expression to their awareness of direction. However, the much more striking phenomena was the more general denial of immediate control or direction. If this is taken as reflecting the reality of the situation as experienced by such lay staff, then the significance of this very absence of direction must be noted. For, if reference is made back to the way nearly all the psychiatrists stressed their 'leadership' role

(1) He then noted how they had to get permission before seeing patients for research purposes, and how this meant having to justify the research design and purpose to the psychiatrists - who often did not understand the rationale.

(2) It seems that the principal social worker had played a rather similar role to that of the prinicipal psychologist in the same hospital, of acting on behalf of the consultant psychiatrist, when reprimanding her junior. See p.313-314.

and the way they felt it was up to themselves to decide on the relevance of the lay staff's contribution, quite apart from the other features of the 'medical mandate', then the very absence of direction, suggests that most lay staff work in such a way that gives the psychiatrists no cause to direct them. This is a somewhat similar point to that made in the previous chapter about the way the current division of labour between the staff is taken to be natural and thus 'inevitable'.

In the analysis of the ideological types in Chapter 6, attention was drawn to the way the welfare workers and testers, in effect define themselves as auxilliaries, whereas the therapists and professionals liked to think of themselves as having a complementary relationship with the psychiatrists. Many of the professional psychologists appeared to be in something of a dilemma over this. For they so qualified the nature of their relationship with psychiatrists that they often characterised themselves as being like 'auxilliaries' while stating they now ought to have a complementary relationship with the psychiatrists (1). The heuristic value of the ideological types can thus be demonstrated when considering the different ways the staff represented the social structure. Within these ideologies, it was suggested that there was a series of interlocking beliefs, assumptions and values about the relevance of their own contribution and that of the other staff, the nature of the division of labour, the legitimacy of the psychiatrists' authority, and so on. It is believed that the compatibility of the lay staff's actions with the psychiatrists' expectations, can to a certain extent, be accounted for by the way all these ideologies, with the exception of the dissident one,

(1) This relates back to what was said earlier on, about the way psychologists can establish 'good' relations with particular psychiatrists, even if they are regarded as auxilliary 'technicians' by others.

stressed the need to be 'realistic' in accepting the psychiatrists 'legal' responsibility. Quite apart from the question of the psychiatrists' authority, nearly all the staff noted how rarely they disagreed with the psychiatrist over matters to do with the patients. This suggests an underlying consensus, not only over the questions of who does what, but over the structure and function of the mental health services. Of course many criticisms were levelled against the 'inadequacies' of the present services, even if many also expressed a sense of hopelessness or fatalism about changing things. As one therapist social worker said "Perhaps in a hospital like this things tend to be the way they are because they are the way they are"(3602) (1). In this way many of the lay staff imbued their working relationships with a certain facticity. A consequence of this reification being the perception of working arrangements as being 'natural', 'appropriate' or 'inevitable'. It is important that subjectively many lay staff felt there was little direction over them, for in reality this may have been the case. But this does not mean that they necessarily had autonomy towards their actions, other than over those that fell within the boundaries that had been established by themselves, or by their own seniors, who were themselves acting on their interpretations of the psychiatrists' expectations. That they may have imposed boundaries around themselves, after experiencing disapproval, is an interesting example of the way control and stability is often maintained within institutions that seek to win the moral involvement of their members.

That other staff were conscious of being directed, suggests that there were not only differences in working relationships, but also different expectations for both self and others within these relationships. So many

(1) Some lay staff expressed the view that there was no point in disagreeing or trying to change anything,as one of them put it, "I am feeling increasingly impotent, and I no longer see any point in raising my voice in objection" (2601).

qualifications were expressed by the lay staff about their relationships with psychiatrists, that it would be a mistake to suggest that it was only the dissidents who felt themselves to be the most constrained. However, they wre the most forthright in saying where they thought they were constrained, and with locating the basis of their problems with the psychiatrists authority, rather than with the personalities or levels of maturity of themselves or the psychiatrists.

People who occupy subordinate positions with the social structure of various institutions, often have no choice but to resort to collective action in order to improve or merely defend their positions. The extent to which either of the lay occupations were considering this solution, as well as several other related questions, will be considered in the second part of this chapter.

Part 2: The psychologists' and social workers' sense of professional identity

Carr-Saunders and Wilson in 1933 noted how "The attention of the public is called to the existence of a profession through its professional association, and public recognition can hardly be accorded to a group that has not discovered itself" (p.295) (1). While not agreeing with the attempts of Carr-Saunders and Wilson and other 'trait' theorists to discover the essential attributes of a profession, the above quotation draws attention to a very important aspect of the professionalisation

(1) Further on they state that "A profession can only be said to exist when there are bonds between the practitioners, and these bonds can take but one shape, that of formal association" (p.298).

process. That is the need for members of an occupation to have 'discovered themselves' and to be aware of a shared identity and interests, if they are to claim a mandate over certain knowledge or activities. Clearly, the attempts of both the British Association of Social Workers and the British Psychological Society, to create greater unity among their members, through creating standardised training courses and the registration of 'qualified' members, as well as other public relations exercises to improve their image and bargaining position, can be seen as attempts to gain such public recognition. In Chapter 4, a brief and necessarily sketchy account of recent developments within both occupations was given.

While it is important to consider such associational developments, the focus of this study is upon the nature and reality of such processes to the members of these occupations. The aim of this study was never to evaluate whether or not any of the occupations under consideration should be regarded as 'professions' (1). However, it is relevant to ask how far the members of these occupations have 'discovered themselves'. For this question has a direct bearing on the extent to which these occupations can be seen to be challenging the current dominance of the medical profession. Although some references will be made to the psychiatrists attitudes towards their professional association (the newly created Royal College of Psychiatry), the concern of this chapter is with the extent to which the subordinate groups have firstly a developed sense of a 'professional' identity, and secondly the extent to which they are seeking 'collective' solutions to the

(1) That is in the traditional manner, of assuming that certain associational developments can be taken as being indicative of a change in status and function. The problems raised by talking about 'professionalisation' were discussed in Chapter 2 and need not be repeated here. But, in so far as certain factors can be considered as hampering or aiding the process of professionalisation, that is the gaining of control over the application of certain knowledge, then it is relevant to examine the role of those factors that were noted in Chapter 5.

problems that face them. It is believed that if either of the lay professions are to be considered as presenting any sort of collective challenge to the medical profession, as opposed to individual members, gaining more favourable positions for themselves, then the members of these occupations must share a sense of a common identity and collective interests.

The lack of unity within these occupations has been noted on several occasions throughout this study. Indeed, the ideological types were constructed in order to illustrate the far reaching differences of outlook between groups within these occupations. Reference will inevitably be made to these differences, especially as an important feature of the 'dissident' ideology, and to a lesser extent that of the 'welfare workers' was their anti-professionalism. Also, of course, the term 'professionals' was chosen to designate the largest group of psychologists, because of their concern to professionalise their occupation. At the same time, the initial focus will be on the contrasts between the attitudes expressed by these occupations taken as a whole. The analysis is based on answers to a series of questions, that sought to find out the attitudes of the staff to the question of registration within their own occupations (1), the functions of their professional association and whether or not they wished to join it, whether or not they would ever consider having recourse to their professional association, if faced with problems at work, and finally whether they would ever consider the use of collective action (2). As the

(1) At the time of the interviews, the BPS differentiated between its members, according to their qualifications, while BASW was in the process of doing the same. Within both groups, especially the BPS there was talk of seeking legal registration that would involve an Act of Parliament.

(2) The replies to an earlier question on whether or not it was better to work from within departments or teams were also considered relevant to this issue.

replies to these questions can be categorised, if somewhat crudely, into a few possible types of responses, several tables are presented that summarise the differences between the staff. As with other tables in this study, they are given for illustrative purposes, not as substantive evidence.

Quite apart from the different replies to the questions listed above, that will be considered separately, a table was constructed that differentiates the social workers from the psychologists in terms of their desire for a 'professional identity'. Table 29 presents an overview and a summary of the subsequent tables, as the staff were allocated to one of the three categories according to their replies to the above questions, and other relevant comments made during the interviews.

Table 29: Professional identity

	Keen	Indifferent	Anti	No.
SW	11 (28.9%)	18 (47.4%)	9 (23.7%)	(38)
Cp	15 (55.6%)	7 (25.9%)	5 (18.5%)	(27)

The point that the psychologists were much keener to establish themselves as 'professionals' is readily apparent in this table. The indifference of the social workers may have been partly due to the reorganisation of social work that was being effected during the period when these interviews were carried out. If this was the case, then the subsequent tables may also have been affected.

Registration

Table 30: Attitudes towards establishing a register of members

	In favour	Yes, but..	No (Against)	No (not bothered)
SW	12 (31.6%) ((55.2%))	9 (23.7%)	7 (18.4%) ((44.8%))	10 (26.4%)
Cp	16 (59.3%) ((74.0%))	4 (14.8%)	4 (14.8%) ((25.9%))	3 (11.1%)

Quite apart from being much more in favour of having a register of members, the psychologists were more aware of the implications of having one, and also of the moves being made by the BPS to establish one. In contrast, several social workers made such comments as "I didn't know there was going to be one, and I am not particularly bothered anyway" (3602). The psychologists were at least all cognisant of the issue of registration, and their comments that it would enable them to "control standards" (2501), "sanction recalcitrant members" (2402), "enable us to get insurance cover, and thus be responsible for our own patients" (2800) and "be more like the medical profession" (2803), demonstrated their awareness of the consequences of such a move. Some expressed the hope that it would not make the profession "too rigid and hierarchical, like the medical profession" (2803), although that was precisely what one of the principal psychologists appeared to hope for (1).

(1) 2800 commented that "I would like to see the same kind of paternalistic hierarchy for psychologists as exists for the medical profession. This would create a greater sense of identity and commitment as one moved up the ladder. We need more on going, in service training, such that one is always 'practicing'. I would also like to see the title consultant used more often, with all that this implies - that more head psychologists will have consultant capacities, responsibilities and salaries". In fact, at Oakdene, the principal psychologist had already adopted the title of 'consultant', much to the annoyance of the medical consultants.

Whereas many social workers in favour of registration, qualified their approval by pointing to the problem of who to exclude, this did not appear to be a particular concern of the psychologists. No doubt this was a reflection of the fact that all clinical psychologists have at least a first degree in psychology in common. But, as one social worker observed

> "I think it is essential that there is a register of trained people, but I also acknowledge that many social workers who have had no training are very worthy and competent individuals" (3505).

Significantly, among the social workers, there was the clearest split of all over this issue, within the local authority department. The higher proportion of ex-psychiatric social workers within the local authority may account for this greater desire for registration, than within the hospitals. Also worth noting was the way that all four of the social workers from the antipodes were unequivocally in favour of registration. To quote one of them "Very definitely, I disagree very strongly with the way this country employs social workers who are not professional" (3601).

As already noted, the dissidents stood out from the other staff in their opposition to such developments as registration. One merely commented that "It's a load of bloody balls, I can see no reason for it whatsoever" (2802). Another that "It reflects the paranoia of those psychologists who think they have something to offer, whereas in fact they have nothing" (2503). Others tended to dissociate themselves from such activities

> "I don't see why there should be a register, but I suppose the trained ones want to separate themselves off from the lower minions. But I don't identify with social workers in general, or feel a part of a body and so I am not too concerned about it" (3503).

The more general grounds for the opposition of the dissidents to becoming professional will be returned to further on.

Expectations of the professional associations

The difference between the social workers and psychologists emerged again in their attitudes towards their professional associations. As Table 31 shows only a third of the social workers, compared with three quarters of the psychologists, expressed 'favourable' attitudes towards their associations.

Table 31: General attitude to the professional associations*

	Pro	Anti	N/R	No.
SW	14 (36.9%)	22 (57.9%)	2 (5.3%)	38
Cp	21 (77.7%)	6 (22.3%)	-	27
Ps	22 (57.9%)	13 (34.2%)	3 (7.9%)	38

* The psychiatrists were asked about their attitude towards the formation of the Royal College of Psychiatry.

In fact 60% of the social workers did not appear to belong to any 'professional association'. Of those that did, 36.8% belonged to BASW (1). Among the psychologists, 77% were members of the BPS (2), while 50% of the psychiatrists were members of the R.M.P.A./R.C. Psychiatry (3). The differences between the social workers and psychologists were reflected

(1) Five were full members, 9 associates, 6 were in the process of applying, 5 were not eligible and 13 were either opposed to BASW or not interested.

(2) This was mad e up of 11 full members, 5 associates, 5 student members.

(3) A variety of qualifications were expressed about the formation of the Royal College. Some ('doctors') thought it unnecessary, others stressed how important it was for it to keep close links with general medicine, while others wished it to establish closer links with other disciplines. Some were quite hostile towards it - especially those who were likely to be excluded from membership.

in their expectations of their associations. The lack of interest shown by some social workers was reflected in such comments as "It can do what it likes as far as I am concerned" (3513). At the same time there were the more professionally orientated 'therapists' who wanted it to "standardise and improve training" (3203), or "act as a forum for the discussion and exchange of ideas" (3506). A few referred to it "fostering a distinct identity" (3601), while there were some other references to creating greater unity among social workers. Also there were expressions of a desire to see "BASW acting as a pressure group on behalf of our clients, drawing attention to housing needs and other social conditions" (3207). However, it was only a minority who made reference to how BASW should

> "Help safeguard the profession - it needs to have more status. The idea of the 'flat hat' image of social work should be obliterated. Apart from increasing the salary, there are so many qualifications in social work that need to be standardised, as well as raising the general academic level"(3507).

Such professionalising sentiments were much more frequently expressed by psychologists.

More significantly, the psychologists were much more acutely aware of the need for the BPS to function to "advance and improve our professional image" (2501), to "create a sense of common identity" (2905) or to "create greater solidarity" (2900). Altogether 12 psychologists mentioned such functions while a further seven references were made to "contacting isolated psychologists" (2400) and providing 'support' for them. As Table 30 demonstrated, several referred to the need to establish a register (1), and for the BPS to further the interests of clinical psychologists

(1) The Foster Report came out towards the end of the interviewing period, and some of those that were interviewed at the time, pointed to the need for the BPS to pre-empt the BMA in drawing up recommendations for a register of psychotherapists.

> "It should be fighting to promote the acceptance of clinical psychology as a profession in its own right, and to give it much greater weight and backing" (2500) (1).

Several referred to the impending reorganisation of the NHS and need for the BPS to

> "Operate as a pressure group and create sufficient group identity to ensure that we have a safe and real place in the development of the reorganised NHS" (2900).

Many of them also mentioned what might be termed the traditional academic functions of a professional association, such as "getting out the journal" (2600), "setting standards of training" (2402), "organising conferences" (2502) and so on. A few were in fact critical of the BPS, as opposed to the Clinical Division, for being "too academic and ivory towerish" (2401), while a few others wanted it to be "more like a trade union" (2804). Further on, there will be reference to the way a sizeable number of psychologists wanted the BPS to operate much more as a bargaining body in resolving certain disputes. The dissident psychologists, like those among the social workers, either expressed their opposition to the BPS, or their dissociation from it. As one of them commented

> "There are some people around who want to raise our status and make psychology into a 'scientific discipline', but for my part I neither care to raise our status, or be considered to be scientific" (2504).

From these and other comments by psychologists, there emerges a sense of psychologists themselves, being aware of not only a need to develop an appropriate professional identity, but also a lack of security over their positions within the NHS structure. By way of contrast, many of the social

(1) Another talked of "Fighting for certain rights, defining and formulating standards and an ethical code - getting this accepted. Putting over its, that is, our point of view, in the corridors of power" (2902).

workers, while giving expression to the 'need to create greater unity', did not appear to be anywhere near so concerned about their futures (1). This may have been a consequence of the fact that social workers in hospitals always have a major source of alternative employment within local authorities. But it is also believed that this reflects the greater acceptance of social workers within the hospitals themselves. This issue and the contrasting positions of the social workers and psychologists can be illustrated by the greater importance that the latter attached to maintaining their own departments within the hospitals in which they worked (2).

Departments or teams?

Table 32: Attitude to working from a department or as a member of a ward team

	Pro department	Both	Pro team	N/R	No.
SW	4 (10.5%)	4 (10.5%)	16 (42.1%)+	14 (36.8%)*	38
Cp	15 (55.6%)	6 (15.8%)	6 (15.8%)	-	27

+ 13 of these were working in Woodlands.
* All of these were working in the local authority department.

(1) This must be immediately qualified by differentiating a concern over the reorganisation of social work, which was worrying many of the 'welfare workers' from the reorganisation that might stem from within the NHS, such as the closing of the specialist mental hospitals, etc.

(2) In recent years in the BPS Bulletin there has been a debate among psychologists over the desirability of seeking to establish separate departments of clinical psychology, that would be free from any outside, ie medical control. Having a department has consequences for an occupation's members that go beyond merely having their own accommodation. In one sense it does indicate a degree of recognition and a granting of autonomy by the medical profession and the hospital administrators, and might give the members of the occupation a securer place within the hospital. It also means that junior members are more accountable to their seniors, rather than to the psychiatrist with whom they are working. This has the further consequence of the senior members often mediating for the medical profession, when controlling their own juniors.

Throughout many of the interviews with the lay staff there were expressions of ambivalence and uncertainty over whether or not it was better for them to be permanently attached to particular teams and thus to be working from the wards, or whether they would not be better off maintaining, and working from their own departments. Many noted how working on the wards afforded immediate access to patients, as one social worker pointed out

> "One of the reasons why I came to this hospital (Woodlands) was the working on the units - you are able to see all the patients and you are not dependent upon the doctors for referrals" (3511).

However, others were also aware that, as a psychologist noted

> "there is a danger of becoming 'yes men', if we are part of the doctor's team. If asked to do things we consider unethical or a stupid or a waste of time, we might find it difficult to refuse if we are not working from an independent department" (2903).

Interestingly, those lay staff who were the most fully integrated into unit teams, that is the social workers at Woodlands (and also the one on the therapeutic community ward within Ashbury), expressed the fewest doubts about the arrangement (see Table 32). In contrast, the social workers at Ashbury, who worked from a department while also being attached to certain wards, all stressed the need to have a department. Their reasoning was very similar to that used by psychologists in a similar position to themselves (that is, combining both having a department as a base, yet working upon certain teams). That is, they talked about "we are able to support one another as a group, with our own identity" (3600) or "feeling I have somebody behind me all the time is very supportive" (3604) or, as one of the more dissident ones put it "At the moment there is an advantage in having the social workers together as they can bolster one another up" (3603).

Echoes of these feelings came even more strongly from the psychologists throughout the various hospitals, with many references to a department

providing 'mutual support', 'a sense of belonging and cohesion', 'security' and a 'common identity'. As 2403 expressed it "you can talk about, we, my, our colleagues - it gives us solidarity". Some specifically mentioned how they needed a department, in view of their training function, and how trainees, in particular, needed such support. (Several social workers also referred to this.) Others were more specific about the need to "insulate ourselves from the dominance of the medical profession" (2803) (1). Overall, though, the most frequent references were to need to have a department in order to foster a distinct 'identity'. As 2904 expressed it

> "I think there is a problem, but not so much that it is with us as not being here yet. Perhaps we have to separate ourselves off so as to establish our identity before we can merge with the other disciplines. I think we have to be recognised first. We tend to be rather unassuming and we could easily get lost, without a formal identity".

There were, of course, many comments about the need to also work closely with the ward teams. Indeed, at Woodlands, there was a bitter disagreement between one of the probationers in particular, and her principal, over her wish to be involved upon the wards. As she commented on the way the principal had "stopped me going onto the wards, he said I was getting too identified with the ward and not enough with the department. But having this department is all nonsense, psychologists feel so incredibly insecure so they all stick together and insulate themselves from the other disciplines by keeping in 'their' departments" (2503).

The principal psychologists reasons for objecting to his juniors working all the time on the wards, further illustrates the importance that

(1) 2903 gave an account of an incident at his previous hospital where a consultant had insisted that a psychologist carry out behaviour therapy upon a woman who was refusing to have a hysterectomy. He went on to say "If you have an independent department, then it is always there at the crunch, if asked to do something which we don't agree with, we can always go to our principal who can go and argue it out at the GMC if necessary".

many psychologists in particular, attached to developing a distinct identity. In his own terms, he believed that

> "our activities have to be research based and we need a department to get this validation done. It's only through having a separate department that we will be able to make a unique contribution. If we all disappeared onto the wards, then we would only be contributing as individuals, not as professionals" (2500).

This particular conflict between a junior and a senior member of an aspiring profession, casts light on a neglected aspect of professional socialisation, and also the means by which control is maintained within professions. Bearing in mind the way most senior psychologists, stressed how they had built up 'good working relations' with particular doctors, or within the hospital as a whole, they clearly did not want to have these disrupted by junior members of their departments 'unprofessional' behaviour. (It appeared that a consultant had requested that 2503 should no longer work upon his unit, because of her 'over-identification with patients and her irresponsible behaviour'.) That this was not only an issue for the psychologists, was illustrated by a reference the principal social worker in the same hospital made to there being a

> "problem, in that many of our trainees come here with totally unrealistic expectations about the sort of the therapy they will carry out with patients. This is one of the reasons why we try to keep a balance on the units between the trained and the untrained" (3500)

Such control and the expectation that they develop an appropriate 'professional identity' was particularly apparent to the dissidents among both of the lay occupations. Indeed, as already noted, it was the resistance of some of the juniors within these occupations to becoming professional that drew attention to them. One of them stated very clearly, what many others hinted at, when he made the following comment upon art therapists

> "It can be useful and its main contribution is to allow a bit of madness into the hospital, it lets patients get away from the system. But it can be used in turn to define and further categorise the patients. But it gets so precious, when you get 'art therapists' and training

courses and qualifications. I begin to disparage it when you get Art Therapy as a reified profession. I have seen people help patients an awful lot as people, but never as professionals. And the ones that are good at it, are usually in trouble with their own profession" (2801).

Elsewhere, he clearly states his own opposition to qualifying as a psychologist (he had refused to sit the qualifying exam), while many other dissidents either directly stated their wish not to be 'thought of as a social worker', or else stressed how they wished to simply "relate with the patients as an individual" (3504), even if they did not go so far as those who stated their intention not to qualify or not to stay within the profession.

Thus, a consideration of the professionalising intent among the grass roots of these occupations reveals some quite divergent tendencies. At one level it would appear that the psychologists are further along the road to making themselves appear more professional, in so far as they were much more united over the need to have a register, and to be members of their association. In contrast, the social workers were much more divided over this, with evident bitterness being shown by some of the 'welfare workers' at the way they were being 'cast off' as a consequence of restrictive membership policies. In fact, although the psychologists as a group showed a greater wish to become more professional, very few of them were actively involved with their professional association (1). Further, the psychologists evident concern over their 'identity' and their need to 'support one another' in their working situations, can be taken as perhaps indicating both greater professional self consciousness

(1) Only 6 said they had either stood for office or would consider doing so. The majority were not at all interested and several commented on how little they had to do with the BPS and how boring they found its conferences. Among the social workers, there was a similar number of people who had been involved at the office holding level.

and also a less than secure place within their hospitals. Their concern to maintain separate departments and the apparent close interaction between the members of these departments, testified to the latter tendency.

Somewhat paradoxically the social workers appeared to be in almost the opposite situation of enjoying much greater security of tenure and evident acceptance within the hospitals, yet at the same time not being as concerned about their 'identity' as the psychologists. This might be taken as simply a reflection of their greater acceptance within the hospital system. Evidence for this being the way far fewer social workers related their professional freedom to their relationships with certain doctors in the way that most psychologists did. However, this lower level of concern over their 'identity' can be considered to be paradoxical because their very acceptability may be due in part to their greater maliability and willingness to take on a variety of tasks, that more 'professionally' conscious groups might consider demeaning. The psychologists, for example, demonstrated greater resistance to being seen only as 'testers', than the majority of social workers did to being valued for their welfare work. In other words, it is the very lack of a distinct identity that makes the social workers acceptable, whereas the psychologists concern to make a 'unique' contribution from which to develop a professional self regard, makes them also much more aware of the tenuous nature of their acceptance within the present hospital structure.

At another level, within the occupations themselves, divergent tendencies can also be illustrated. These divisions are so marked in some instances that it becomes rather misleading to talk about these occupations as unities without referring to the differences within them. This is especially so among the social workers, in the split between the therapists and welfare workers, and between the professionals and dissidents among the psychologists. The problem that the welfare workers pose for the professionalising

therapists may be resolved in time, through the requirement for qualifications. However, although many welfare workers were unqualified, there were several who had taken professional courses, thereby showing that this particular approach to social work transcends merely the question of qualifications. The 'problem' of the dissidents may solve itself, through their departure from their occupations (1). However, there have been signs of the emergence of various fringe and splinter groups within both occupations, that provide rationales for staying within the health and social services, so as to subvert them from the inside (2). How successful the actual attempts of a few radical psychologists, to prevent the 'professionalisation' of psychology, will be, remains to be seen. The very fact that they are being made though, provides support from the 'associational level', for the existence of the conflicts that have been discovered at the practitioner level during the course of this study.

In the introduction it was observed that in recent years, various professional associations have been involved in various forms of collective action. This can be seen to be a relatively new trend, and may reflect a change in the meaning given to such action by middle class occupations. It was also suggested that new, and aspiring occupations may have greater recourse to use their professional associations to defend their interests, if they feel these to be threatened. Certain questions were asked about these issues during the interview, and the replies suggest further

(1) Altogether 9 of the dissidents (including the psychiatrists) are known to have given up working in the capacity they were doing at the time of the interviews.

(2) Amongst the psychologists there is Red Rat and more recently Humpty Dumpty, both of which have contained articles on how radical psychologists can or cannot justify continuing to work within the NHS. While among social workers, (in general) there has been Case Con. that has organised meetings, etc. at which this issue has been debated endlessly.

differences between all three occupations that are worth considering.

Collective Action

As already noted, there were quite marked contrasts between the three groups over their attitudes towards their respective professional associations. Both a third of the social workers and psychologists expressed the view that in various ways their professional associations should be 'bargaining' bodies. This contrasted sharply with the psychiatrists who were much more likely to stress how it should maintain the 'status' of their occupation, through various status enhancing activities. More important than this though, was the extent to which the members of these occupations would be prepared to enlist the aid of their professional association when faced with problems in their work situation. This question and subsequent ones that are asked about support for collective action, can be considered as being important in two main ways. Firstly, the answers provide further material on the social structural position of the three occupations and the ways in which this might be changed, and secondly, have bearing on the wider question of white collar unionisation and militancy.

The table below demonstrates that the psychologists were slightly more prepared to consider having 'recourse of their professional association, if faced with problems or difficulties in their work situation', than either of the other two. At the same time many of them expressed how 'useless' and 'ineffective' their association was, and how little good would come out of it. Those who have been classified as saying 'rarely', often stated how they would only consider doing so after 'all the internal channels

had been exhausted'.

Table 33: Attitude to use of professional association

	1 Yes	1 + 2 (In favour)	2 Possibly	3 Rarely	3 + 4	4 Never	N/R
Ps	2 (5.3%)	(26.4%)	8 (21.1%)	13 (34.2%)	(65.8%)	5 (13.2%)	10(26.3%)
Cp	6 (22.2%)	(55.5%)	9 (33.3%)	8 (29.6%)	(40.7%)	3 (11.1%)	1(3.7%)
SW	8 (21.1%)	(50.0%)	11 (28.9%)	13 (33.3%)	(46.5%)	5 (13.2%)	1(2.6%)

In the course of replying some such respondents, and thos who replied 'never', stressed how unlikely it was that their relationships with other staff should deteriorate to the point at which such action would be necessary. Some indicated how they would change their place of work if such a situation arose (1). Bearing in mind, what has been said about the psychiatrists viewing the 'division of labour' as being more natural, than either of the other two groups, in the previouschapter, these figures demonstrate the different perspective that 'subordinate' groups take towards their professional associations. This question can also be illustrated by reference to the views expressed on the more general question of collective action.

As Table 34 below demonstrates, the social workers, and to a lesser extent, the psychologists, were much more likely to favour 'the use of collective action'.

(1) As might be expected, there were differences between the ideological categories with the doctors, welfare workers and testers coming down against, more often than either the dissidents or the 'therapists' et al.
Yes/Possibly Doctors et al - 29.5%, Therapists et al - 50%, Dissidents 57.1%
Rarely/Never Doctors et al - 68.6%, Therapists et al - 46.1%, Dissidents - 35.7%
It should be noted that many dissidents tended to dismiss their professional associations as being 'irrelevant'.

Table 34: Attitudes to collective action

	Yes	It depends	No	N/R
Ps	9 (23.7%)	10 (26.3%)	18 (47.4%)	1 (2.6%)
Cp	14 (51.9%)	4 (14.8%)	8 (29.6%)	1 (2.6%)
SW	24 (63.2%)	7 (18.4%)	5 (13.2%)	2 (5.3%)

While indicating the greater 'militancy' of the social workers, this table does not have much meaning unless it can also be shown over what sort of issues they were prepared to use collective action. Table 35 below provides some indication of the range of issues that were mentioned. These have been grouped into four main columns.

Table 35: Reasons for use of collective action

	Defence of interests(1)	Pay Conditions (2)	Better Service (3)	Nothing
Ps	2 (5.3%)	7 (18.4%)	12 (31.6%)	17 (44.7%)
Cp	14 (51.9%)	2 (7.4%)	2 (7.4%)	9 (33.7%)
SW	5 (13.2%)	13 (34.2%)	13 (34.2%)	7 (18.4%)

(1) In this column are included references to specific comments about 'more autonomy', 'gaining recognition', 'outside interference'.

(2) Apart from references to their own pay some staff also mentioned action for other staff's pay.

(3) This included references to 'improved facilities for patients', 'better psychiatric services', 'more local authority hostels/ services', etc.

The most significant point to emerge from this table is the fact that over half of the psychologists expressed some concern about the possible need to defend their interests. At Oakdene in particular, attention was drawn to the way they had already threatened to resign en masse, over the question of the 'activity centre' (1). This table lends support to the points made earlier in this chapter about the greater sense of security among the social workers than the psychologists. The greater willingness of the social workers to resort to collective action both for their own pay, and also for better services for their clients, provide indications of the increased militancy of this occupation. This militancy was noted in Chapter 4, and has been shown in recent actions by groups of local authority social workers in support of their clients. The fact that the social workers were more concerned about their pay may be seen as reflecting the dissatisfaction that existed at the time, over the differences between the pay of hospital and local authority social workers. Also, the older age of the social workers, and their wider 'previous work' experience may have led them to be more concerned about these issues.

Conclusions

This chapter has been concerned with many separate yet related issues.

(1) This was a unit that was attached to the hospital's school, and was being run by the principal psychologist, with the help of outside volunteers. A new consultant, who had been given responsibility for the children's side, had insisted that the activity centre by brought under medical/nursing control. The psychologists were opposing this on the grounds that they believed the children benefited from it, because it was outside of their control and hence free of the medical model of care.

It has been placed towards the end of this thesis as it contains some partial answers to some of the questions raised during earlier chapters. Going back to one of the early questions that informed the start of this study, namely the standing of, and relationship between the psychiatric 'professions', it was considered necessary to establish the extent and nature of the autonomy enjoyed by these occupations. But as the analysis of the lay staff's 'sense of freedom' demonstrated, it is extraordinarily difficult to establish the extent of their autonomy. As noted in the introduction to this chapter, this question becomes one of consciousness, in so far as many staff believe themselves to have 'complete freedom'. However, when such claims are related to the sort of tasks that such staff carry out, it appears that the question becomes one of 'false' consciousness, in so far as these staff have limited conceptions of their own role. In Chapter 6, the ideological types were described as illustrating the way certain definitions of situations, such as 'having autonomy', can only be understood by relating them to a wide range of interlocking attitudes, beliefs, and assumptions that sustain such definitions. In Chapters 8 and 9, further evidence was presented of the way large numbers of both lay occupations, not only the welfare workers, 'tread very carefully', in making sure that they do not 'step on the toes of the psychiatrists'. Consequently, they never become aware of the nature of the boundaries surrounding themselves. They have imposed them themselves, and they are consequently taken to be 'natural' and inevitable.

According to much of the literature on professionalisation, an occupation can be considered to be a profession when it has gone through certain stages. In Chapter 2, various objections were levelled against this approach to studying professionalisation, for its failure to concern itself with the meaning of 'professionalisation' to actual members of

the occupations concerned, and further for its failure to consider the actual working situations of members of aspiring professions. In this chapter there has been an attempt to assess both of these questions. If the situation of the social workers and psychologists are compared, it can be shown that the sense of professional identity among their members, varies according to the nature of their working situation, and more importantly according to the degree of their acceptance by the psychiatrists. Thus, the question of professionalisation, must be brought back to a consideration of the power relationships between occupations that work within the same institutional contexts.

The question of the power relationships between the three occupations under consideration, is however, an exceedingly complex one, as this chapter has sought to demonstrate. While being aware that the psychiatrists have more power than themselves, many lay staff deny that this has any effect on how they work. By pointing to their freedom to take on which ever patients they like for therapy, some are able to suggest that their professional skills are recognised. At the same time though, many such staff would also note how, they 'were fortunate' in working with particular psychiatrists, or how they 'did not enjoy the same trust' with other psychiatrists. In other words, both lay groups and especially the psychologists find that they are only able to carry out the sort of tasks they believe themselves qualified to do, if they have established particular relationships with certain psychiatrists. Further, when the general 'liberalism' of many psychiatrists is considered and also such factors as the rapid turn over of staff, it becomes apparent that sooner or later most lay staff will work with a psychiatrist who tolerates, approves of or even encourages them to carry out more therapy, research, or whatever else it is they wish to do. But, for the same reasons, established positions and 'good' working relationships can be lost and dissolved over night, when

the particular psychiatrists leave or move to different teams. It has been suggested in this chapter and in earlier ones that the psychiatrists interviewed in this study, were, with a few exceptions, quite prepared to accept that non medical staff be 'involved' with patients. It was also quite apparent that this acceptance was conditional on the lay staff involving themselves in ways that were approved of by, and 'watched over' by the psychiatrists (see Chapter 7). In this chapter, it has been suggested that the extent to which the lay staff were aware of this 'supervision' varied, and that some never became aware of it, because they did not step outside of their own taken for granted conceptions of what it was appropriate for them to do. Others, were aware of it, but did not find it 'restricting', while a minority were openly hostile towards it.

If it is accepted that being 'professional' involves having control over the application and practice of certain knowledge and skills, then the present social structural position of both occupations, cannot be considered as enabling either group to be fully 'professional'. To be dependent on the good will of individual psychiatrists, can hardly be considered as constituting the recognition that having control over certain required skills usually elicits. But as soon as the question of skills, knowledge or expertise is raised, then the general uncertaintly over who can do what must be considered. It was pointed out in Chapter 9 that the psychologists appeared to be more highly trained at carrying out psychotherapy. In this present chapter, it has been shown how the psychologists were much more professionally conscious. At the same time, they did not appear to have as secure a tenure, within the mental hospitals in which they were working, as the social workers. The general insecurity of the psychologists would appear to have led them to be much more united, and generally much more concerned about 'protecting their interests' and

'defending themselves'. However, while certain confrontations had occurred between individual psychologists and psychiatrists, the only example of the psychologists resorting to their professional association for help, was that of the psychologists at Oakdene.

The fact that social workers were less professionally conscious, could perhaps be accounted for by the nature of their educational attainments, relative inexperience and the other factors that were noted in Chapter 5. Such an explanation though, would not appear to go far enough in accounting for the lack of interest, and often stated opposition, to the 'professionalisation' of social work. For some of the older social workers there was a genuine fear that they would be excluded from membership of the reorganised profession. But from many others, there was also a stated preference for seeing the work to be about 'helping people' without having recourse to either theoretical knowledge with which to understand them, or control over the process through which help is given. Social workers find themselves to be 'in demand' in mental hospitals and they are clearly accepted by the psychiatrists as being essential, in a way that the psychologists were not. Further, as many of the social workers' activities and tasks, can be carried out without necessarily affecting the immediate treatment of the patient, they are in their own terms 'very free' as to how they carry out these tasks. Perhaps the low level of professional aspirations among the social workers can in part be attributed to the current social structural situation of social workers, who often themselves feel 'no need' to change things.

The conclusions that can be drawn from this chapter inevitably involve referring back to the earlier chapters. It is the task of the concluding chapter to draw together the various interlocking themes that have been developed in this thesis.

CHAPTER 11

CONCLUSIONS: PROFESSIONAL PROCESSES AMONG THREE MENTAL HEALTH OCCUPATIONS

Introduction

This study was originally prompted by an interest in the question of how the medical profession has in practice managed to dominate the treatment of 'mental illness'. A study that was to be about a single occupation was quickly expanded to include two others, and it could easily have included more, had it not been for the limitations of time and funds that surround single researchers. The focus of the study broadened, when it became apparent that there appeared to be a very interesting situation of an established occupation, with a clear mandate to treat physical illness, also dominating the institution in which the treatment of 'mental illness' was carried out. Further, it also appeared that there were other occupations involved in the treatment of mental illness, occupations that could make as strong, if not stronger claims, to be as knowledgeable about mental illness, as the medical profession. For many psychiatrists, the question of why medical dominance? can be answered by reference to the possibility of physical illness, assertions that mental illness is an illness, or merely that drugs are required by some, if not all, patients. In Chapter 7, the analysis of the 'medical mandate' aimed to draw out the various ways in which psychiatrists seek to defend their dominant position. Some psychiatrists found it surprising that this question be asked at all, so obvious was the answer. However, the extent to which the lay staff qualified their approval of the psychiatrists claims in Chapter 8, demonstrates how the psychiatrists' views on these matters cannot be taken as the only ones to be listened to.

This Chapter will therefore begin with a consideration of the question

'why medical dominance?', in order to demonstrate how the various themes that have been developed have a bearing on this question. This will involve looking at the question from both the standpoint of the psychiatrists and of the lay staff. After that, the position of the two lay occupations will be considered, in the light of what has been said about the ways in which the medical profession maintains its position, with the often unwitting help of these occupations. The implications that this study has on recent policy changes will then be considered. Throughout this study there have been references to various processes such as 'accommodation', 'personalisation', 'particularism' and, to a lesser extent, 'collusion'. These will be commented upon as examples of the professional processes identified by this study.

Why medical dominance?

In the first chapter of this thesis, it was observed that of all the occupations working alongside psychiatrists, or in other ways involved in the treatment of mental illness, the social workers and clinical psychologists might be thought of as being in the best position to challenge the authority and methods of the psychiatrists. This assumption was derived from a reading of some of the American studies, and the comments of some of the 'spokesmen' for these occupations. As it turned out this early 'hypothesis' was quickly discounted once the field work was started, not only because of the denials of any conflict between the lay and medical staff during the interviews, but also because it was observed during attendance at ward rounds, staff meetings and other events, that there was a general sense of harmony and common understanding. Evidence of such 'good team work' cannot, of course, be taken at its face value,

without further investigation into the various members' conceptions of their own role, their view on that of the other staff, and also the legitimacy they accord the authority structure. Quite apart from their views on the way the treatment should be carried out. The ideological types, originally described in Chapter 6 were developed in order to demonstrate, how within each of the occupations under consideration, there were important differences that must be considered when talking about 'team work'. Further, it is believed that the existence of such differences helps to maintain the dominance of the psychiatrists, in ways that are often unintended by the lay staff themselves. Before considering the particular way in which the ideological types contribute towards answering this question, the more general ways in which the lay staff legitimised the psychiatrists' mandate should be considered.

To begin with, nearly all the lay staff appeared to accept certain tenets of psychiatric practice as being necessary, if not sufficient, for the treatment of mental illness. This could be seen in the general acceptance of the medical model of mental illness as being the only practicable basis from which to treat insanity. Quite apart from the general acceptance of psychiatric labels and diagnostic categories that followed, there was a general belief that certain tasks belonged to the psychiatrist. These included such activities as deciding on whether or not to admit the patient, carrying out the initial diagnosis of both the physical and mental state of the patient, deciding on the initial treatment and mode of care for the patient. These and many other 'routines' were seen as medical routines, as if it was inevitable that psychiatrists should carry them out. Clearly, at the present time, and bearing in mind the legal responsibilities of the psychiatrists, they might be expected to be the staff to carry out such tasks, but many lay staff appeared to believe that they were also the 'natural' staff to carry out these, and

other strategically important activities. In some respects such activities are the 'dirty work' of the psychiatrists, that many find to be onerous and not particularly satisfying, but the consequences of this administrative control over the fate of the patient, can mean that lay staff only gain access to patients on terms that are laid down by the psychiatrist.

Quite apart from the acceptance and therefore de facto legitimation of the more limited and restricted aspects of the medical mandate, there were lay staff who clearly expected the psychiatrists to have a much greater knowledge of nearly all aspects of the patients condition and situation and to provide direction and supervision over the activities of the other staff. Such staff tended to be the 'welfare workers' and 'testers', although many of the 'professionals' and 'therapists' also talked of how the psychiatrists should know more, and be more skilled at psychotherapy, while also providing 'coordination', instead of the 'leadership' expected by the welfare workers. It should be noted though, that the lay staff as a rule did not expect the psychiatrists to act as leaders, as much as the psychiatrists themselves seemed to believe it was expected of them. As detailed descriptions of the differences between these ideological categories have already been given in Chapter 6, there is no need to repeat them, other than to stress how such differences should be kept in mind, when reference is being made to the occupations in very general terms. However, the consequences of these divisions on the question of medical dominance can best be seen after noting certain attitudes and actions of the psychiatrists.

To begin with the very diffuseness of the claims being made by the psychiatrists and their apparent tolerance of the ambiguity that arises from combining biochemical explanations with psychological and 'sociological' ones, as some believed themselves capable of doing, when allied to their pragmatic stance towards the lay staff, enables them to justify their

superior position through reference to certain 'common sense facts' about the treatment of mental illness, while at the same time appearing to have no actual control over the actions of the lay staff. Indeed, many psychiatrists, especially the 'eclectics' seemed to believe that it was part of their mandate to positively encourage the lay staff to contribute 'to the best of their abilities'. However, even the 'doctors' who talked more of 'direction' than the eclectics, were also respectful of the autonomy of the lay staff over such matters as the running of their departments, the organisation of their work loads, or how they collected the information they requested from them. As was pointed out in Chapter 7, the social workers were accepted very readily as essential members of the 'team', even if a 'limited' view was held of the tasks they should carry out. The psychiatrists were much more equivocal about the role of the psychologists, mainly because they did not fit into their scheme of things, as the social workers did, but also because they were not 'functionally indispensible' in the way that social workers were. However, the important point about the psychiatrists in this context, is the way their general acceptance of the right of the lay staff to be involved with patients in various ways, has the consequence that the psychiatrists can expect, and to a large extent, they receive, a degree of reciprocal recognition from the lay staff. Through such mutual 'recognition' of each others role, a set of <u>accommodating</u> and almost <u>collusive</u> relationships appear to develop that would appear to contribute to maintaining the dominant position of the psychiatrists. Once such relationships are established, the infraction of the norms governing them, would undermine the basis of the 'team work', that everyone appears to take for granted, is a good thing. Further features of these relationships will be considered below, but before doing that, there are certain consequences of the way the psychiatrists were divided among themselves that should be noted.

Although it might appear that the divisions among the psychiatrists would weaken their claimed mandate, in so far as the various claims would appear to relativise one another, they can also be shown to strengthen their position. To begin with, such differences when experienced by the lay staff serve to justify the view that 'you cannot generalise about the psychiatrists'. In other words, the faults and limitations of some psychiatrists, can be set against the merits and evident abilities of others. More importantly than this, many lay staff noted how while they had a very restricted role to play with certain psychiatrists, they at least worked with another who allowed them 'to do as they liked'. However, such 'good' relationships are not established without the compliance and cooperation of both parties and more importantly there is a need to establish a 'working consensus' about each others role. While this might arise from a mutual recognition of one anothers skills, it appeared that a more important consideration was the nature of the personal relationship established between the staff concerned. That is both medical and lay staff affirmed the importance of the <u>particular</u> relationship that they had with certain other staff. This was especially the case with the psychologists who were often almost entirely dependent on the good will of certain psychiatrists if they were to undertake therapy with patients. As long as they were able to establish and maintain such relationships, many lay staff seemed prepared to reconcile themselves to their organisational subordination. In this way they often unwittingly affirmed the legitimacy of the psychiatrists dominance.

On several occasions both the psychiatrists and lay staff working on the same unit affirmed 'how well they got along together'. Such evidence of harmonious working relationships often occurred where it seemed that 'welfare workers' were working alongside 'doctors' and 'therapists' alongside 'eclectics' (the situation of the psychologists has to be left

on one side, because of the lack of material on the psychiatrists with whom the majority of psychologists were working). In these circumstances, the explanatory value of the ideological types can be shown. For it was often the self-limitation and assumption of the existence of certain boundaries by the welfare workers, that appeared to make their views of themselves, compatible with those of the psychiatrists with whom they worked. The therapists (and also 'professionals') made similar assumptions, but with more broadly based and more diffuse views of their own role and that of the psychiatrists. In their case, if they were fortunate enough to work with the more 'liberal', eclectic psychiatrists, then they were given 'considerable freedom', providing they had established a working consensus with them. The irony being that the eclectics, while ostensibly granting the lay staff greater recognition often undermined such regard by suggesting that the roles of the different team members were 'quite interchangeable'. On occasions they also appeared to be more in control of what happened on their units, as part of their ideology was the belief that they should participate, along with the other staff in all aspects of the hospital life. A further important element in the 'centre' ideologies was the belief that while the psychoses were definitely for the psychiatrists to deal with, the neuroses and personality disorders could best be dealt with by some form of psychotherapy, to be carried out by the psychologists or social workers. It appeared in several of the settings, that certain arrangements existed between particular psychiatrists and a member of the lay staff, whereby patients of a certain type were referred to the lay therapists, while the psychiatrist treated other patients without reference to the opinions of the lay staff. Such arrangements enable lay staff to <u>accommodate</u> themselves to the situation they find themselves in when working in mental hospitals, and consequently many become committed to maintaining that structure of relationships. This is particularly the case with many

senior members of the lay occupations, who are able, over many years, to establish good working relationships with particular psychiatrists. As many of them affirmed, they had 'mutual understandings' about who should do what to whom. A consequence of such understandings being the concern shown by the senior members of the lay occupations, lest their own juniors should disrupt such arrangements. This does not mean that the senior members of these occupations merely sycophantically follow the wishes of the psychiatrists. Indeed, many were quite outspoken in the criticisms of the inadequacies of the psychiatrists training, abilities and general orientation, but they tended to suggest that the only way to change things was through a gradual persuasion of the psychiatrists that they could be trusted to act 'responsibly' with their patients. Having gained this trust, they believed they would be able to show them that they were more capable therapists. The consequence of this 'reformist' approach being the initial acceptance of not only the medical model and all that goes with it, but also the current dominance of the medical profession in the institutions in which mental patients are treated.

There are other ways in which the attitudes of the psychiatrists can be seen to contribute to their legitimation in the eyes of the lay staff. Beliefs about mental illness have not been given much prominence in this study, but there have been several references to the way in which the majority of psychiatrists presented themselves as taking 'non-ideological' and 'eclectic' approaches to treatment. Further, many psychiatrists pointed out how they were 'only too aware' of the importance of social, psychological, environmental and other 'non medical' factors in causing, or bringing about mental illness. It was not possible to test how far, if at all, the actions of such psychiatrists were affected by this knowledge. However, it would appear that with the exception of a few 'doctors', that the lay staff also

perceived the psychiatrists as being 'non dogmatic', and thus more acceptable in their eyes. The position of psychiatrists can thus be seen to be strengthened by such eclecticism (1). It not only enables them to claim that they know about everything and thus are in the best position to judge the merit of various ideas, but further that their very adaptability and tolerance of opposing views and theories, when tinged with the pragmatic realisation that they after all have to do something about the patient, makes them appear the 'realists', whereas others who criticise them are 'idealists' or committed to an 'ideological' standpoint. Some psychiatrists indeed go beyond this to suggest that because of the sheer variety of views expressed on the subject of mental illness, that all views can be relativised by setting them one against another. While this might undermine their own position, it can also be used to strengthen it by suggesting that at least they, unlike other staff, have the ability to judge the merits of all the different theories, while being guided by their overall responsibility for the patient's interests.

The lay staff - a professional challenge or personal accommodation?

One of the assumptions that would appear to underpin several of the earlier theories on professionalisation, has been the belief that members of aspiring professions are highly self conscious about the aims and mandate being claimed by their occupation. Thus, assured of their own

(1) It might seem somewhat confusing to use the term eclecticism in this context, in view of the way the same term has been used to describe one of the ideological categories. But as pointed out in Chapter 6 there are certain overlaps between the doctor and eclectic ideologies, and the belief in their own eclecticism was one such area of overlap.

superior knowledge and ability, they are able to confront other occupations, interest groups and the State with demands for recognition of their right to control the application of certain knowledge. An important finding of this study has been the discovery that many members of these allegedly professionalising occupations, demonstrate neither awareness, interest or concern about the attempts to professionalise their occupations. Indeed, contrary to the belief that members of the professions take their work to be of 'central life interest', there were several indications (in Chapter 5) that many of the people who were interviewed were not as committed to their occupation as such theorists would suggest. The general state of ignorance and more importantly lack of interest in the activities of the professional associations was a striking finding of this study, and it suggests that other studies on the 'professionalisation' of certain occupations should pay more attention to this aspect of the process. The lack of unity to be found among these occupations might have been expected, however, the form the divisions took, in the particular institutional context in which the majority of the interviews were carried out, may be distinctive to such settings (1). It has been suggested that the position of the psychiatrists was strengthened as a consequence of the differences among them, and it would seem appropriate to consider how far the lack of unity among the lay staff strengthened or weakened their position in relation to that of the psychiatrists.

This question can only be answered by examining the current state of these professions as appeared from the field work of this study. Before

(1) There is a problem here of including the local authority social workers in with the hospital staffs. However at the time, the social workers concerned were more solely concerned with 'mental patients/clients' and some attended regular out patient clinics and ward rounds at Ashbury.

considering them individually a few general points can be made about the position of the lay staff. To begin with, most social workers and psychologists have considerably more autonomy and control over their daily lives than the members of almost any other occupation working with in mental hospitals. The psychologists in particular often had virtually no formal requirements upon them, other than a certain amount of teaching and assessment work. In this respect they were often 'freer' than the psychiatrists whose daily work was often largely the carrying out of certain routines, or obligations that were not entirely of their own choosing. Throughout this study there have been references to the problem of the meaning to be attached to this 'freedom'. It has been argued that statements about having the 'autonomy to do as one likes' can only be understood if they are related to the wider conceptions that the person held on their tasks and those of the other staff. In other words reference has to be made to the ideological differences between the staff in the way they defined their own situations, expertise and role in the hospital. Such ideologies it was suggested contained more than merely certain descriptive statements about the situation that the members of staff found themselves in, but also prescriptive assertions about how the situation ought to be. The problem being that this distinction was not always clear. However, this very confusion would appear to reflect the genuine ambiguity and lack of clarity confronting nearly all the staff in their attempts to describe the situation in which they were working. In certain situations the staff could make definitive statements about their own role and that of the other staff, such situations usually occurring where the 'treatment' came closest to a traditional medical pattern, such as on the psychogeriatric wards. The point of this qualification about the need to consider the ideological differences, being the fact that those staff who asserted they had 'complete freedom' often had the most restricted view of their own role, and thus

were the least likely to encounter attempts to limit them to certain activities.

It is necessary to emphasise the role of the ideologies in understanding the professional processes, because they point to certain important features of the position of the lay staff. The generally higher status that both social workers and psychologists have in mental hospitals than that awarded to other staff, may be taken as a sign of recognition of their professional role, but it may also stem more from their higher educational attainments and the similarity of their class backgrounds to that of the psychiatrists (1). But the meaning to be given to such recognition though can only be understood if related to the ideologies found among the psychiatrists and the lay staff. A trend that was observed among both the social workers and the psychologists was the attempt by the more professionally conscious to define their tasks and skills much more widely than they were given credit for by most of the psychiatrists. But while such occupations can make general claims to have a better academic and theoretical knowledge of the processes involved in conducting psychotherapy, they can hardly claim to be more skilful than the psychiatrists at the level of practice. This is because most of them affirmed how success as a therapist, was largely dependent on 'what sort of person you are'. Such personalisation of ability was widespread among all the staff, both medical and lay, and it can be seen to be something of a double edged weapon, as it can be used both for and against the various claims that were made. More importantly in this immediate context, it would seem unlikely that either social work or clinical

(1) Even so in all the hospitals there were evident, if subtle, status differences between the staff over such matters as eating arrangements, facilities, attendance at seminars. As a rule the psychologists were more likely to join the psychiatrists on certain occasions than the social workers. At Woodlands the psychologists had a joint seminar with the psychiatrists, but they were excluded from their dining room. At another hospital (the Willows) the psychologists were the only lay staff to eat in the 'doctors mess'.

psychology are going to produce a body of knowledge and techniques that will be able to supercede the pragmatically based knowledge of the psychiatrists, bearing in mind the nature of the task that currently confronts the staff of mental hospitals. That is to say, the present institutional imperatives that are felt by all the staff in a mental hospital, can be most readily met by adopting the medical model, and all that goes with it. The present institutional arrangements may be able to incorporate experimental and alternative models on a short term basis, but any genuinely radical alternative is unlikely to arise from within the present hospital services. These issues will be dealt with further on, they have been raised here as a reminder of the way the 'utility' of the knowledge of the lay staff, is largely judged in terms of its value for psychiatrists, who are the members of staff who tend to articulate the nature of such constraints acting upon them and the other staff. A consideration of some of the main points to emerge on the two lay occupations will serve to illustrate the problem of the nature of the challenge that they are making to the psychiatrists.

The social workers

One of the problems that has been present throughout the course of this study has been the way in which the organisation of social work has been changing. While an attempt has been made to keep abreast of all the developments within social work, the concern of this study, is with those social workers who have mental patients or ex-mental patients as their clients, and therefore it is the changes that have affected these social workers that have a bearing on this study. The merging of social work specialisms, however, has meant that in theory all social workers will carry a generic

work load and thus may have to deal with mental patients. The argument put forward by the Seebohm report (1968) was that quite apart from the organisational reasons in favour of generic social workers, all the different specialisms employed the same 'casework' skills and relied on the same body of social science knowledge. It is too early to say yet whether the new social services departments, with their control over a much wider range of facilities and resources, will be able to provide extensive non-medical care for potential 'psychiatric patients'. Certainly some psychiatrists have expressed fears that they may lose large sections of their more curable patients to the social workers, before they ever reach them. But in view of the estimates that exist at present, for the large number of 'mentally ill' people who are not receiving any form of attention, medical or otherwise, an increase in the numbers being seen by social workers, may not threaten the psychiatrists very much. It would seem that in terms of the theory of professionalisation that has been advanced in this study, social workers in general have gained considerably more control over the application of their knowledge and skills, since the creation of the Seebohm type, Departments of Social Service. But in their actions, many social workers remain subject to the interference of the bureaucratic forces that impinge on their work. More importantly, in particular working situations such as mental hospitals, and other settings where social workers work alongside the more established professions, they have not been accorded the recognition that they have in the local authority departments. It is significant that there has been a prolonged controversy over whether or not social workers should be employed by hospitals, or be attached to hospitals but at the same time be employed by local authority Social Service Departments. From the point of view of those who wish to professionalise social work, it is important that social workers be members of social service departments that are not as directly under the influence, and hence

'control', of another profession.

An important difference arises between the social workers and the psychologists over this question of who should employ them. While there are some posts for clinical psychologists outside the National Health Service, the majority are employed within it. In contrast, only a minority of social workers are employed by the NHS. This means that social workers always have an alternative source of employment in the local authorities. One of the consequences of this being the way those social workers who choose to work in mental hospitals often have particular reasons for doing so, that may incline them to accommodate themselves to the current order of things, without seeking to change it (1). Many social workers, both welfare worker and therapist alike, stressed how 'if one chose to work in a hospital then one must accept certain limitations' or similar sentiments. Quite apart from the various ways in which the social workers appeared to accommodate themselves to the psychiatrists, the fact that the majority were women may have influenced their more circumscribed occupational ambitions, compared with either male social workers, or the more male dominated occupation of clinical psychology.

Among the social workers the differences between the welfare workers and the therapists were more clearly marked and delineated than those between the ideological types among the psychologists and the psychiatrists. This internal 'conflict' would appear to have a long history in social work and it seems that it will continue for some time to come. Among the claims being

(1)
It was pointed out in Chapter 5 that many of the social workers were in 'training' and thus their commitment to their present posts was provisional. Apart from these, several other of the older, married social workers, explained their choice of their present place of work in terms of its convenience, the possibility of part-time employment, their preference for mental patients, or in general their preference for hospital work.

made by the more dissident social workers, was one for a reassertion of the value of the more material forms of assistance over the giving of psychological 'insights'. Such divisions among the social workers can hardly be seen to strengthen the 'front' they show to the psychiatrists. In the previous chapter, the hostility, distrust and apathy that many social workers expressed towards their recently formed professional association was taken as reflecting the way that social workers have hardly 'discovered themselves', let alone begun to make united claims about the nature of their expertise. The problem remains though for social workers, that the more esoteric activities that some wish to involve themselves in, are also carried out by other staff, while those activities over which they claim to have a special understanding, such as interviewing relatives, or investigating the family relationships of a patient or even taking a social history, cannot be restricted to social workers.

The clinical psychologists

Unlike the social workers who have at least an alternative source of employment in the local authorities, clinical psychologists are much more restricted to working in the NHS, unless they choose to work in another branch of psychology. In this, and in other ways, the dilemmas confronting the psychologists were much more acute than those facing the social workers. Whereas the social workers can feel their work has some relevance for the patients, the psychologists in their own terms, often find themselves to be 'irrelevant luxuries' that could easily be dispensed with. This is particularly the case with regard to the assessment work of psychologists. With few exceptions, they did not consider this had much value; a view that accorded with the estimation placed upon them by the psychiatrists. Where

the psychologists differed from the psychiatrists though, was their belief that they could contribute in many other ways to the life of the hospitals, if they were given the opportunity. As a rule the psychologists were much more self consciously trying to expand their role than were the social workers. This was particularly the case at Wheatbury, where the psychology department was issuing a series of policy statements and advisory documents, on different problems within the hospital. As noted in Chapter 7, the psychiatrists tended to regard the psychologists to be more of a 'problem' than the social workers. Perhaps as an unfortunate consequence of the choice of hospitals, the psychiatrists that were interviewed had much less direct contact with the psychologists, than was the case in the hospitals where only psychologists were interviewed. This may have led to a more restricted view of the role of the psychologists being presented than would otherwise have been the case. However, the findings of this study would appear to confirm the picture of clinical psychology that was presented in Chapter 4.

New occupations often arise around the development of new techniques and clinical psychology itself owes its origins to the application of psychometric techniques in mental hospitals. As these techniques have been superceded and relegated to the nether regions of the occupation, it might be thought that behaviour therapy and other 'technical' means of therapy, derived from learning theory would have been embraced by clinical psychologists as a means of justifying their existence in mental hospitals. In view of the small numbers to be interviewed, no claims can be made for this study to be representative of clinical psychologists as a whole, but it is still surprising that only a handful, expressed anything other than passing interest in behaviour therapy. Significantly, many psychiatrists expressed more interest in behaviour therapy than some psychologists, and at one of the hospitals, it had been pressure from a consultant that had led to

one of the psychologists undergoing training in this form of therapy. Overall though, the majority of psychologists, while not being hostile to behaviour therapy, tended to regard it as trivial, and not the method through which to advance the claims of clinical psychology. Although at Oakdene, there was more interest in applying learning theory on a widespread scale, to the problems of the mentally subnormal. Among the psychologists there was an evident split between those preferring to carry out research and those seeking to do therapy. However, many psychologists were united over the need to be involved in teaching the other staff. Some indeed saw this as being the most effective way to counter the medical model, especially among the nursing staff.

Overall the psychologists were much more conscious of, and united over, the need to professionalise their occupation. Their greater willingness to engage in collective action in defence of their occupation might be taken as an indication of their self consciousness. It could also be taken as a sign of their vulnerability, for at the same time as expressing support for the idea of collective action, most psychologists qualified their approval by pointing out how ineffective it would be, as no one would be affected by it. Such awareness demonstrates the acuteness of the dilemmas confronting the psychologists.

Policy implications

During the course of the field work for this thesis, many of the staff who were interviewed, noted how talking about the issues with which this study is concerned, had helped them to understand the problems that they faced. While it is hoped that this study will be of some value to the staff

who are its subjects, it should be evident that the primary concern of this thesis has been to contribute to a sociological understanding of psychiatry as a social institution. It would clearly be for members of the occupations concerned, to decide whether or not the findings of this study, have any bearing on the problems that they face. However, it is possible to point to certain implications of this research, on the likely structure of relations among the mental health professions.

Reference has already been made to the problems that both the social workers and psychologists face, when confronted by the established power of the medical profession. For psychologists, the problems are likely to be much greater, until they can establish themselves in institutions and treatment settings, over which they have control. Apart from this study's contribution to an understanding of the likely course of the 'professionalisation' of these occupations, it would appear to suggest that the 'problem' of staff relationships among the mental health occupations, will not simply be overcome through 'improved communication', for increased 'mutual understanding'. It should be noted how many staff testified to the 'harmony' and 'good team work' to be found among their colleagues, but at the same time this study has revealed how many staff felt such harmony was only on the surface. The question of how patients are treated, by whom and with what, ultimately comes back to a question of the power and control of those staff who define the terms on which patients are treated. Thus any attempt to resolve the problems of disputes over 'who should do what' must begin with an examination of the question of authority and control. However, the evidence of this study is that most mental health staff resist such an analysis, and instead prefer to analyse their problems in terms of the personalities, and the particular relationships that they have with other staff.

It was noted in the first chapter that this study was primarily concerned

with the processes to be found within mental hospitals, rather than within other settings, in which psychiatrists, social workers and clinical psychologists come together. Consequently, it might be thought that the findings have little bearing on the situation in other settings. However, many of the staff who were interviewed, drew upon their experience in other settings during the interview, as the questions were orientated towards general issues, rather than particular situations. Further, and more importantly, the 'team work' principle of staff relationships was as well established in most of the mental hospitals, as it is likely to be in the new general hospital units. In other words, the creation of psychiatric units in District General Hospitals, is likely to simply transpose the situations found in this study to new buildings. The basis of the, agreement and disagreement between the medical and lay staff is likely to stay the same. It is significant that the British Psychological Society has issued statements and policy documents opposing this change. It has been argued that mental patients require special facilities and much non medical attention, that may be denied them in general hospitals, where a medical and thus more organic approach is expected to predominate. However, although some psychiatrists have welcomed the advent of the policy change, there are others who have expressed fears that the distinctiveness of their own speciality, may be threatened by such a move.

The other major policy change that has had a bearing on the treatment of mental patients, has been the reorganisation of the local authority social services. This has already been referred to as giving social workers greater autonomy, even though sections of the medical profession have sought to restore their control over some of the services. But while some psychiatrists may have occasion to lament the passing of their 'efficient mental health teams' in the local authorities, it is unlikely that they have much to fear from social workers attempting to wrest the treatment of mental

illness from their hands. For if the social workers interviewed for this study are at all typical, it would seem that most of them accept certain tenents of psychiatric practice, and thus were more concerned to work with, rather than against the psychiatrists.

Finally, it would seem appropriate to refer to the recent concern that has been expressed over the shortage of staff to carry out psychotherapy. One of the findings to emerge from this study, is the widespread support for the view that some form of psychotherapy, will provide a more lasting and beneficial 'therapy', than those treatments that merely supress symptoms. Further, it seems that ability to be a psychotherapist has little to do with formal training, and even less to do with having a medical training. But at the same time, it appears that psychiatrists continue to assert that they are the staff best able to decide who should carry out psychotherapy, and to carry it out themselves if they feel so inclined. Thus the conclusion of this study would be that lay staff will have to organise themselves more effectively, if they are to extend the provision of psychotherapy, without having this service directed by the medical profession.

Conclusions

In the first chapter of this thesis, it was observed that this study was ultimately, if indirectly, concerned with the treatment of mental illness. The social processes that have been identified in this study may have little immediate bearing on the patients themselves, but they can certainly be seen as affecting the structure of the treatment services, and thus the patients. The treatment that patients receive would appear to be largely determined by the available distribution of staff, their orientations

and the autonomy that they enjoy, to engage in the form of therapy they consider appropriate. There are limited human resources available for caring for mental disorder, and increasingly these resources are controlled and distributed through the 'professional' mode of social organisation. But the influence of such professions, once established, goes beyond that of merely resolving the problems with which they are confronted, for such 'experts' generally seek to impose their definitions of the terms on which their services are provided, overthose of laymen, whether patient, relative or interested third party. This thesis has been largely concerned with an examination of the social processes whereby the psychiatrists seek to subordinate the lay occupations. By extension, it can be seen to have a bearing on many comparable situations, where 'experts' seek to keep control over the application of certain knowledge and skills.

This thesis has also been concerned with demonstrating how the meaning to be given to the process of 'professionalisation' can best be understood by speaking directly with those who are experiencing it. In some respects the major limitation of this study has been its reliance on the opinions of such staff, without any check on the 'accuracy' of their statements. But this limitation can also be seen to be one of the strengths of this study, for through an analysis of the 'ideas' and the views that the members of these occupations held of themselves, it has been possible to identify different ideologies that give expression to various aspects of the process of professionalisation. The variety of views expressed, having suggested that this process is more complex, than earlier theorists have presented it to be. Thus, this study of 'professional processes among three mental health occupations' has hopefully contributed to the sociological understanding of both psychiatry and professionalisation.

APPENDIX 1

NOTES ON METHODOLOGY

The purpose of this appendix is to provide certain details on the way in which the field work material for this study was collected. In Chapter 1 certain general theoretical and methodological points were made, while in Chapter 5 a brief account was given of the reasons that lay behind the choice of settings. Elsewhere in this thesis other points that have a bearing on the methodological approach that has been taken have also been raised, as for example in Chapter 3, in the discussion on the problem of conceptualising 'ideology'. These notes are therefore primarily concerned with giving an outline of the practical procedures used in order to gather the material that this study has been based on. Some of the problems that were encountered are also commented on, as these have a bearing on the 'slice of reality' that has been presented in this thesis.

To begin with the initial 'pilot' stage of the study. After some preliminary conversations with various members of the three occupations, an interview schedule was drawn up. Several members of these occupations were then approached and asked if they would cooperate in this preliminary investigation. In all there were ten 'pilot' interviews. Material from these interviews has not been included in this thesis. Before the interview schedule could be altered and amended, to take account of the various deficiencies within it, it had to be used for the interviews with the local

authority social workers (1). Thus, these interviews were neither as detailed nor extensive as subsequent ones, although various issues were raised that were to be subsequently incorporated in the final interview schedule. (A copy of this schedule is in Appendix 2.) The interview schedules were always thought of as being more guides than fixed instruments to be rigidly followed. During the interviews themselves, it was frequently necessary to improvise and amend the schedule, but before considering the reasons for such improvision, it is necessary to briefly point to the way that access was gained to the settings.

Having chosen the settings, according to the criteria set out in Chapter 5, letters were sent simultaneously to the Chairman of the Medical Executive, the Principal Social Worker and Principal or Consultant Psychologist in the hospital concerned (see copy of letter in Appendix 2) (2). Such letters were usually followed by a visit to the setting concerned to explain the aims, methods and possible outcome of the research. At most of the settings, only the 'principals' were seen, but at Woodlands a meeting of the Medical Executive Committee was attended, in order to explain the aims of the research to all the psychiatrists (3).

(1) As frequently happens during such investigations, permission was given to carry out the interviews within a particular time period. There was consequently no opportunity to amend the interview schedule before carrying out these interviews. The material collected from the local authority social workers has not been given as much prominence in the thesis, as that of the hospital social workers, for this and other reasons. The other reasons being, the general focus of the study has been mainly on the hospital situation, while to have examined the local authority services in detail would have also meant interviewing in a child guidance clinic. The limitations of funds and time that face single researchers, played their inevitable role in restricting the focus of the study.

(2) At the hospital at which only psychologists were interviewed, only the 'senior' psychologist was approached.

(3) It is significant that at this hospital, with its therapeutic community philosophy, the psychiatrists chose to exert a veto over whether or not this research should be carried out, after both the lay occupations had agreed to it. It appeared that the psychiatrists were split over the issue and only agreed, because of the pressure by some of the junior doctors that it be allowed.

While at both Wheatbury and the Willows, meetings were arranged with all the psychologists. At such meetings and again before the interviews were carried out, assurances were given of the way the material that was collected would be treated as confidential, and further that the anonymity of the interviewee and setting would be preserved. Once it had been agreed that the research could be carried out, individual appointments were made with each relevant member of staff, as to the time and place of the interview (1).

Before any interviews were carried out, a period of time, varying from a few days to a few weeks, was spent with different members of staff, attending both staff and patient meetings, group therapy sessions, ward rounds, and other occasions where the staff came together such as at meal times, coffee breaks and other social gatherings. Such time was a necessary and invaluable way of gaining background information on the settings and the subjects, and further providing an opportunity for the staff to familiarise themselves with the researcher. The information that was gathered during the periods of non-participant observation has not been systematically recorded in this thesis, but it played an important role in guiding and at times altering the direction of the study, and further in sensitising the researcher to issues that would not have come to light, had the interviews been carried out without this period of observation (2). As the substantive material for this study was collected through the

(1) Considerable persistence and flexibility had to be shown in order to obtain interviews with some of the consultants with reputations for being elusive, 'distant' and unobtainable.

(2) Becker and Geer (1967) have written in some detail of the importance of such work.

interviews, there is no need to discuss the problems encountered during this period of observation. However, one problem should be noted, as having a bearing on the response of some staff towards the interviews. As a general rule the social workers and clinical psychologists, were more approachable, sympathetic and interested in the research than the psychiatrists. Consequently, they made themselves more available, at times offered suggestions, and in general encouraged the researcher to spend time with them. While such interest was gratifying it also brought certain problems with it. At times certain members of these occupations, were almost explicit in asking what other people had said. The expectation being that their disclosure of confidences would be reciprocated. However, such situations could usually be handled by referring to the need to uphold ones prior assurances of confidentiality (1). More importantly than this though, was the tendency of some psychiatrists to associate the researcher with the social workers, and thus to see the research as 'biased' (2). This arose partly as a consequence of the general lack of understanding among psychiatrists, as to the distinctiveness of sociology from either social work or psychology, and also because more time was spent with the lay staff because they were more approachable, and thus the researcher was seen to be 'more with them, than us' (3). When it came to

(1) The principal social worker at Ashbury made things particularly difficult in this respect, in so far as she asked for information on what her juniors had said. She had also begun by welcoming the research, but later seemed to consider it against her interests, and in several ways sought to sabotage it.

(2) One psychiatrist persisted in equating the researcher with the social workers, and initially refused to be interviewed as 'it would be biased'.

(3) All sorts of problems arise in the daily management of the role of researcher in such situations, particularly over the conduct of relationships and knowing when it is, or is not appropriate to be present at certain situations. For example, at times the researcher ate in the 'doctors' dining room, but there always appeared to be an unspoken assumption that as a lay person, the general staff canteen was the appropriate place, etc. See Olesen and Whitaker (1969).

the actual interviews, it was also the case that the lay staff were generally prepared to make more time available, but there were exceptions and the shortest interview of three quarters of an hour was with a principal social worker, while the longest of almost six hours (spread over three sessions) was with a consultant psychiatrist.

On average, the interviews lasted about two hours with several running to three or four hours over two sessions. The open ended nature of the questions meant that some staff gave very short, almost monosyllabic answers to questions that others spent twenty minutes answering. Such differences made the task of comparing the interviews a difficult and somewhat problematic affair. But before considering such problems, it is necessary to note a few other features of the interviews. The first is that with one exception, all the staff who were approached, finally agreed to be interviewed, although a few expressed some reluctance, on the grounds referred to above, or because of 'lack of time'. In view of the evident pressures on the time of all the staff concerned, the 99% response rate, and the amount of time given for the interviews, can be regarded as quite an achievement in itself, as well as testifying to the willing cooperation of the majority of the staff who were approached. The interviews themselves were recorded by hand, and it is believed that an almost full account and record of what the interviewee said, was written down. At the pilot stage of the field work, a tape recorder was tried, but it was decided to record the interviews by hand, partly because some people are ill at ease with a tape recorder, but more importantly because of the problems that are created when transcribing the recordings. Such problems are mainly ones of resources, either financial or time (1). In contrast a written recording

(1) It was estimated that to have had all the interviews transcribed, if they had been tape recorded, would have cost between £500-£600.

can be more readily analysed (1). Clearly, the choice of such a method means that a part of the interview is missed, not only through omissions but also as a consequence of having no record of voice inflections, pauses, and the full range of expressions used.

The interviews themselves were conducted along the lines of a conversation as far as possible. This meant that the exact order of the questions in the interview schedule was not always followed, and some questions were omitted or supplemented when it was thought the interviewee had already covered certain issues of their own accord. The less important questions were placed towards the end of the interview schedule in anticipation of the need to omit them, in the event of there not being sufficient time. The problems this raises for the analysis of the interviews will be considered further on, but first there are other points to be noted about the conduct of such interviews. Interviewing and conversely being interviewed is nearly always a problematic affair. This is particularly the case when the interview concerns matters that have a bearing on the subjects self conception and sense of moral value. Several of the questions that were asked and many of the issues being investigated could have been interpreted as casting doubt on the interviewees professional knowledge, and general awareness of the matters affecting them. In such situations there may well be a tendency to give a safe, standard and almost 'textbook' response. On other occasions, the interviewee appeared to give a completely predictable answer, because it seemed they thought that was expected of them. Here the question of the sympathy of the interviewee for the aims and tenor of the research played a part; on occasions certain staff conveyed a very

(1) All the interviews were subsequently typed out. This in itself was time consuming but necessary, as in the process of analysing the interviews, each one had to be read and re-read many times over.

clear impression of finding the interview to be an imposition, that had no interest for themselves. Whereas there were others who commented how talking about the issues raised in the interviews had helped them to clarify their position on certain matters. A further problem that was raised in Chapter 1 and which has a bearing on this question of the conduct of the interviews, was the way asking questions about 'mental illness' and 'treatment' quite apart from the general use of such words as 'patients' implied the legitimation and acceptance of the very phenomena that needed to be taken as problematic, for heuristic, if no other reason. In practice, there were some staff who interjected of their own accord, that they did not accept the notion of 'mental illness' or believe in the existence of 'causes' as such. At other times it was necessary to indicate that such terms were being used in inverted commas, and should be seen as merely short hand ways of introducing certain questions.

In all, one hundred and three interviews were carried out. This number was judged sufficient in view of the nature of the problems being investigated. In retrospect, a more detailed and hence qualitatively better study, might have been achieved, if a depth investigation had been carried out in a single hospital. However, the strengths of such an approach are also its weaknesses, as the narrowing of focus may limit the comparative value of the data that is collected. Having embarked on this study with certain aims in mind, it was considered important to sustain the logic of these aims, if there was to be any consistency to the material that was collected. But as the aims were exploratory and somewhat diffuse, it was considered quite legitimate to amend the interview schedule, and hence the 'direction' of the study at various points during the field work.

Once the interviewing was complete, and written records had been typed out, the next problem was that of analysing the material that had been collected. This process proving to be both more time consuming and

complicated than had been anticipated; the sheer volume and variety of the interview material, making categorisation a difficult and initially, arbitrary task. In so far as some of the material lent itself to quantification, tables were drawn up in order to demonstrate the distribution of certain types of response. Such tables have, however, played a subsidiary and secondary role to that of the quotations. The task of selecting quotations, editing them, and fitting them into the text, raised many problems. Not the least being the tendency to choose the more illuminating and colourful comments, in the place of the often more typical, yet less interesting. During the period when the interviews were being carried out, the evident differences between the various staff members were observed, but it was not until the interviews were analysed, that the ideological types 'emerged' as such. As noted in Chapter 6, the ideological typologies were created as means of drawing attention to the evident interrelationships between the attitudes that were expressed. Indeed, many of the responses made little sense when considered on their own. At the same time, the material collected from the short, fixed choice questionnaires, was coded and subsequently transferred to computer cards. This material was then analysed according to a standard social survey programme, so that the possibility of correlations between this data and the ideologies could be examined (1).

There were many problems to analysing the interview material, the evident uncertaintly, ambiguity and often contradictory nature of the

(1) The tables that were produced were examined for any possible correlations, that might account for the ideological differences. The numbers involved were too small to justify including these tables. As might be expected the dissidents were predominantly young (all of them being under 30 years old). A large proportion of adherents to the 'centre' ideologies were male, while there were preponderances of female 'doctors' and welfare workers. The latter groups were also more likely to support conservative political principles.

responses, not being the least of the difficulties. The problem of the uneven 'quality' of the responses has been noted, as has that of the varied quantity of information provided. A further problem being the strict comparability of the interview material collected at the start of the field work, with that collected at the end. However, without wishing to gloss over such problems, it is believed that the material that has been collected and presented, does greater justice to the complexity of the reality that was investigated, than a more 'objective' and quantitative approach would have allowed.

APPENDIX 2

THE QUESTIONNAIRES AND INTERVIEW GUIDE

This appendix contains copies of the letters that were sent out in order to gain access to the various settings, and also copies of the short 'background' questionnaires, and the interview guides. In the actual guides, the spacing between the questions was sufficient to allow for the recording of what was said, whereas in the copy shown here, only a list of the questions is provided.

THE CITY UNIVERSITY

ST JOHN STREET LONDON E.C.1 01-253 4399

DEPARTMENT OF SOCIAL SCIENCE & HUMANITIES

Dear

I am research student at the above university where I am doing work in the sociology of psychiatry for a higher degree. My intention is to interview a cross section of psychiatrists, clinical psychologists and social workers about various aspects of their work, their expectations of each other and their ' psychiatric orientations'. I am hoping to interview staff in several different settings, and it is for this reason that I am writing to you,as I was wondering if I might interview some of the relevant staff in your department.

I realise that I have not given you much information about my research, but I find it difficult to summarise what I am doing in a few sentances. If you are at all sympathetic to my request, perhaps I could visit you and explain in more detail just what my research entails.

Perhaps I should add that I do not require any sort of information on patients, and that any references to places visited, or persons interviewed in any published account of my work, will be kept strictly anonymous.

I will be very grateful to you , for any assistance that you can give me in this matter.

Yours sincerely,

Nigel Goldie.

THE CITY UNIVERSITY

ST. JOHN STREET · LONDON ECIV 4PB · 01-253 4399

DEPARTMENT OF SOCIAL SCIENCE & HUMANITIES

I am a research student at the above university where I am doing work in the sociology of psychiatry for a higher degree. My research has involved the interviewing of psychiatrists, clinical psychologists and psychiatric social workers about various aspects of their work, their expectations of each other and their psychiatric orientations . So far I have attempted to interview all the relevent staff in the institutions that I have visited,but I have found that psychologists are much thinner on the ground than the other two professions that I am looking at. It is for this reason that I am now writing to you as I am anxious to establish contact with a wider range of psychologists.

I realise that I have not told you very much about my research but I find it difficult to summariee what I am trying to do in a few sentances. If you are at all sympathetic towards my request perhaps I could visit you and explain in more detail just what my research entails.

Perhaps I should add that I do not require any sort of information on patients and that any references to places visited or persons interviewed in any published account of my research would be kept completely anonymous.

I will be very grateful to you if you can assist me in this matter.

Yours sincerely,

Nigel Goldie

Code No.

All information given in response to this questionnaire or to oral interview will be kept completely confidential. No one other than myself will see the completed questionnaires. Any reference to individual respondents in any report of this research will be kept strictly anonymous.

Thank you very much for your cooperation.

Please could you answer the following questions either by placing a tick in the appropiate brackets or by writing your answer in the space by the question.

PS.

1) What is your present occupational status?

2) Please give details of formal qualifications that you have;

3) Are you at present pursuing higher qualifications ? Yes ( ) No ( )
(If yes, please give details)

4) To which professional and other associations connected with your work do you belong?
(Please say whether full or associate member)

5) For how many years have you specialised in psychiatry?

6) Before entering psychiatry did you work for more than a year in any other specialty ?
Yes ( ) No ( ) . If yes, please specify which specialty.

7) Which medical school did you go to?

8) Where did you train in psychiatry?

9) For how many years have you worked at you present place of work ?

10) Do you work at any other centre? Yes ( ) No ( ) (If yes, please give details)

11) Do you consider yourself to be trained and/or experienced in any particular form of therapy ? Yes ( ) No ( ) (If yes, please give details)

12) Have you attended training courses in particular forms of therapy ? Yes ( ) No ( )
(If yes, please give details)

13) Please indicate the amount of contact that you have with the following people;

	Every day	A few times a week	Once every 1-2 weeks	Once a month	Once every few months	Rarely if ever
Psychologists	( )	( )	( )	( )	( )	( )
Social workers	( )	( )	( )	( )	( )	( )

14) Please indicate the predominant sort of contact that you have with;

	By letter	Over the phone	Face to face	On ward rounds	Case conferences	None at all
Psychologists	( )	( )	( )	( )	( )	( )
Social workers	( )	( )	( )	( )	( )	( )

1) What is your present occupational status ?

2) Please give details of all formal qualifications that you have:

3) Which professional and other associations do you belong to ? (Please say whether full or associate member)

4) Are you at present pursuing higher qualifications ? Yes ( ) No ( )
(If yes, please specify)

5) Where did you train as a clinical psychologist ?

6) For how many years have you worked as a clinical psychologist?

7) What work were you doing before you became a clinical psychologist ?

8) Do you work at any other centre ? Yes ( ) No ( ) . If yes,please give details;

9) Are there any particular characteristics about the patients that you have MOST contact with in terms of being:

Adult ( ) Child( ) Acute ( ) Chronic ( ) In patient ( ) Out patient ( )
Other ( ) Please state;

10) Have you ever attended training courses in particular forms of therapy ?

Yes ( ) No ( ) If yes, please give details;

11) Do you consider yourself to be trained and/or experienced in any particular form of therapy?

Yes ( ) No ( ) If yes, please give details;

12) Please indicate the amount of contact that you have with the following people;

	Every day	A few times a week	Once every 1-2 weeks	Once a month	Once every few months	Never
Psychiatrists	( )	( )	( )	( )	( )	( )
Social Workers	( )	( )	( )	( )	( )	( )

13) Please indicate the predominant sort of contact that you have with;

	By letter	Over the phone	Face to face	On ward rounds	Case conference	None at all
Psychiatrists	( )	( )	( )	( )	( )	( )
Social Workers	( )	( )	( )	( )	( )	( )

1) What is your present occupational status ?

2) Please give details of all formal qualifications that you have;

3) Are you at present pursuing higher qualifications? Yes ( ) No ( )
(If yes, please specify)

4) To which professional and other associations connected with your work do you belong?
(Please say whether a full or associate member)

5) For how many years have you worked as a social worker?

6) Where did you train as a social worker?

7) For how many years have you worked at your present place of work?

8) What work were you doing before you became a social worker?

9) Do you work at any other centre? Yes ( ) No ( ). If yes, please give details

10) Have you attended training courses in particular forms of therapy? Yes ( ) No ( )
(if yes, please give details)

11) Do you consider yourself to be trained and/or experienced in any particular form of therapy ? Yes ( ) No ( ) If yes, please give details;

12) Please indicate the amount of contact that you have with the following people;

	Every day	A few times a week	Once every 1-2 weeks	Once a month	Once every few months	Rarely if ever
Psychiatrists	( )	( )	( )	( )	( )	( )
Psychologists	( )	( )	( )	( )	( )	( )

13) Please indicate the predominant sort of contact that you have with;

	By letter	Over the phone	Face to face	On ward rounds	Case conferences	None at all
Psychiatrists	( )	( )	( )	( )	( )	( )
Psychologists	( )	( )	( )	( )	( )	( )

As a sociologist I am interested in the various social characteristics of your profession and I would be very grateful to you if you would answer the following questions.

1) Are you: Male ( ) Female ( ).

2) Are you: Less then 30 ( )
30 - 40 ( )
40 - 50 ( )
Over 50 Years of age. ( )

3) What is your marital status? Single( ) Married ( ) Divorced ( ) Widowed ( )

With children( ) Without Children ( )

4) Are you an; Eldest child ( ) Youngest child ( ) Only child ( ) Other ( )

5) At what type of school did you receive your secondary education ?

Secondary modern ( )
Central or Technical ( )
Grammar or High ( )
Public orIndependant ( )
Comprehensive ( )
Other ( )

6) Would you say that you agree with;

Socialist principles ( ) or Conservative principles ( )

7) Which political party did you vote for at the last general election ?

Conservative ( ) Labour ( ) Liberal ( ) Other ( ) Abstained ( )

8) Would you say that your father agreed with;;

Socialist principles ( ) or Conservative principles ( )

9) Would you say that your mother agreed with;;

Socialist principles ( ) or Conservative principles ( )

10) Which religious denomination or church do you belong to ?

11) Which religious denomination or church do(or did) your parents belong to ?

12) Which of the following statements comes closest to your feelings on religion?

I reject religious belief ( )
I am indifferent to religious belief ( )
I believe with some doubts ( )
I believe without any serious doubts ( )

13) What is your nationality?

14) At what stage in your life did you decide to pursue your present occupation?

15) What is(or was) your father's occupation ?

16) What is(or was) your mother's occupation ?

17) What was your mother's occupation before marriage?

18) Society is divided by some people into classes. Which class would you say you belong to ?

Upper ( ) Upper middle ( ) Middle ( )

Lower Middle ( ) Upper working ( ) Working ( ) Lower Working ( )

19) Here are some statements about work and leisure. Please tick the one that most accords with you own view.

Work and leisure overlap for me ( )

Leisure is the chance to be free from work demands ( )

Leisure has no particular relationship to work ( )

20) If you are female and married please could you indicate which of the following opinions your husband hold about your working;

He fully supports you ( )
He supports you but with reservations ( )
He is mildly opposed to you working ( )
He is strongly opposed to you working ( )

21) If you are female and married , please could you indicate which of the following reasons summarises your main reason for working;

Financial ( ) Intellectual stimulus ( )

Enjoyment ( ) Helping other people ( )

Other (please state)

22) Which of the following statements comes closest to your feelings on class ?

Society is divided into two seperate groups; those with power and those without ( ).

There is nothing to stop people moving up the class scale into a group with a higher status ( )

23) Please indicate which(if any)of the following factors influenced you in your decision to work in the field of mental illness;

The experience of mental illness amongst friends or relatives ( )
The scientific challenge of doing research into mental illness ( )
The better career prospects than in poosible alternative jobs ( )
The desire to fulfill personal, moral ,religious or humanitarian beliefs ( )
The intellectual problems posed by mental illness ( )
The provision of an adequate effort without too much effort ( )
Other (please state) ( )

1) What do you consider to be the essential task of a x

2) What do you consider to be the essential task of a x

3) What do you consider to be the essential task of a x

4) How do you relate the work of a Cp with that of a Ps

5) How do you relate the work of a SW with that of a Ps

6) How do you relate the work of a Cp with that of a SW

7) How far is there a natural division of labour between the different professions that work within psychiatry

8) How essential is the contribution of Ps towards the treatment of M/I

9) How essential is the contribution of Cp towards the treatment of M/I

10) How essential is the contribution of SW towards the treatment of M/I

11) How essential is the contribution of O/T (art + drama) towards the treatment of M/I

12) What is the authority structure here - who is i/c

13) Have you a separate department of x

14) What are your feelings on the question of having separate depts of SW/Cp

15) Who has most direct control over how you allocate your time

16) How much freedom have you over how you allocate your time (are you tied to a ward time table, etc)

17) Who has responsibility for the patients/clients that you see

18) How much medical supervision/direction is there over your work

19) How aware are you of medical direction of your work

20) Should psychiatric illness be regarded as being a medical problem

21) How are patients referred to you

22) When a patient is referred to you do you decide what to do or are you asked to do particular things

23) Do you get access to the patients that interest you and are you free to carry out the research and/or therapy that you want to do

24) Who usually decides what happens to a patient (how much influence do you have over what happens)

25) How often do you disagree over treatment

26) Which of the various professional groups do you consider to be most important with regard to the treatment of psychiatric illness

27) What are your feelings regarding the differences of status and financial rewards between the different professions in the mental health field

28) Do you have much social contact with these other professions

29) What do you consider to be the most important qualities/qualifications that a person working with psychiatric patients should possess

30) What sort of a relationship should a therapist have with their patient

31) Do you identify with any of the different orientations that exist within psychiatry

32) Are you particularly hostile towards any of these orientations

33) Is there a particular orientation among your colleagues in this centre

34) What do you consider to be the main cause of psychiatric illness/ breakdown

35) What do you consider to be the most effective form of therapy

36) What do you consider to be the goal of your work here

personal

prof.

37) Do you attach a specific meaning to the psychotherapy

38) In which area do you think there is the greatest need for research or for a re-evaluation of existing concepts

39) Whose favourable opinion of your work would you most welcome

40) If you were in charge of a training course for SW's, Cp's, Ps's - what aspect of training would you stress as being more important

41) Should there be a register of SW's, Cp's

42) What function do you see your professional association serving?

43) Is this the same as your T.U. (NALGO or ASTMS)

44) In the event of problems in your work situation (Re. access to patients or the full utilisation of your abilities, etc. would you ever have recourse to your professional association

45) Would you ever consider the use of collective action by x

46) Over what sort of issues would you consider the use of collective action

47) Have you ever thought of standing for office in your professional association

48) What are your feelings regarding the formation of the R.C.Ps/BASW (will you seek membership)

49) What are your feelings regarding the Seebohm reorganisation of the social services

50) Do you consider that there is a problem regarding who should be able to work with psychiatric patients re. fringe groups, etc.

51) Do you thing that you are able to influence hospital policy

52) Do you support the move to community care

53) Have you ever thought of undergoing psychoanalysis

54) For personal insight or training

55) Would you favour one of the analytic groups before the others

56) Are you particularly interested in any of the psychoanalytic theories

57) Do you/would you ever send patients to psychoanalysts

58) Do you use analytic techniques yourself

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