

**SOCIAL REPRESENTATIONS OF PSYCHOLOGY  
AND THE PSYCHOLOGIST**

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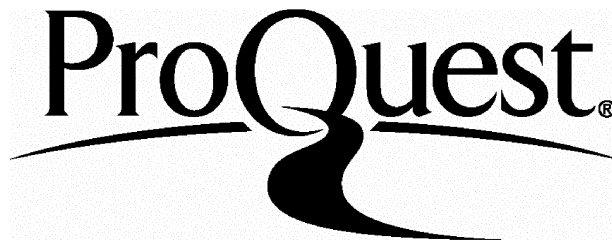
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Are psychologists useful?	95	
What kind of person is the psychologist?	96	
What kinds of emotional responses does the psychologist invoke?	100	
What are the psychologist's clients like?	103	
<b>Discussion</b>	<b>112</b>	
Overview	112	
Social representations of psychology and the psychologist	113	
Consensual findings	113	
Paradoxes and ambiguities	118	
Sex differences in social representations of psychology and the psychologist	128	
Age differences in social representations of psychology and the psychologist	132	
Presence, or absence, of additional representations	136	
Summary of main findings	140	
Methodological issues	142	
Suggestions for future research	150	
Clinical implications	153	
Conclusions	159	
<b>References</b>	<b>163</b>	
<b>Appendices</b>	<b>184</b>	
Appendix I	Letter giving ethics committee approval	184
Appendix II	Information sheet for participants	185
Appendix III	Consent form for participants	186
Appendix IV	Interview schedule	187
Appendix V	Sample transcript	188
Appendix VI	Coding frame	193
Appendix VII	Draft example of possible introductory and information sheet for potential clients	200

## ABSTRACT

This study presents a qualitative approach to investigating public views on psychology and psychologists. Thirty two white British members of the general public who had never had direct contact with psychology services were recruited from community settings in north, south, east and west London (community centres, social clubs and working mens clubs). They participated in a semi-structured interview designed to tap their views on the nature of psychology, its practitioners and its clients. Two age groups were targeted (25-35 year olds and 65-75 year olds), with equal numbers of men and women in each.

A content analytic approach was used to explore what meanings people constructed and assigned to the concepts 'psychology' and 'psychologist', and how these meanings were related to the socio-cultural milieu within the UK at the end of the 20<sup>th</sup> century. The theoretical basis for the study was social representations theory. This social constructionist approach emphasises the reciprocal interdependence between society and the individual, and the extent to which ideas from people's socio-cultural heritage continue to circulate within the public's collective discourse, constraining and shaping people's current beliefs.

The vast majority of the participants seemed to hold social representations of psychology as a clinical discipline associated with mental health, and psychologists as high status medical professionals, akin to psychiatrists or doctors, who are experts in the study of the mind. There was also considerable consensus in associating seeing a

psychologist with themes of threat and stigma. Only a minority of participants, mainly women, also viewed seeing a psychologist as a potentially positive move.

Multiple models of the nature of psychological problems were suggested by the data. The principal emphases were on individual factors and on the role of personal experiences, with little or no attribution of psychological problems to innate 'wickedness', biological inheritance or systemic factors. Most participants viewed the psychologist's expertise as the primary therapeutic agent, with little direct emphasis on the therapeutic relationship.

A number of salient sex differences emerged suggesting that men felt more threatened by psychology than women. The ideas concerning threat and the nature of psychological problems and treatments were common across the two age groups. However, amongst the younger participants there was greater evidence of additional ideas which could make psychology more acceptable to this age group.

The findings are interpreted in terms of social representational and psychodynamic ideas, and discussed in terms of how they complement and extend existing quantitative work and related qualitative studies. Implications for clinical practice and suggestions for future research are considered.

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*Thank you for always being  
"the wind beneath my wings"*

## **INTRODUCTION**

### **OVERVIEW**

As the NHS enters the new millennium, the drive towards ever-increasing effectiveness and efficient use of resources has never been more apparent. In order to meet this demand, it is the responsibility of clinical psychology as a profession to elucidate and address those factors which impact upon service efficiency. One such issue is the quality of the interaction between clinical psychologist and client.

A crucial factor thought to affect this interaction is the nature of the client's expectations (Clinton, 1996; Faller, 1998; Joyce & Piper, 1998; Ross, Frommelt, Hazelwood & Chang, 1994). These expectations may touch upon many issues, including the client's perceptions of what psychology is, what psychologists do and what it means to be seeing a psychologist. It can be argued that such perceptions may not only profoundly affect assessment, intervention and outcome, but may, in fact, be crucial determinants of non-attendance (Clinton, 1996; Garfield, 1986; Goldstein, 1962; Heilbrun, 1970; Hopson & Cunningham, 1995; Morton, 1995; Sandler, 1975; Stones, 1996).

Furthermore, there is evidence that the perceptions of non-clients (Deane & Todd, 1996; Harris, 1994) and other socio-cultural influences (Wright & Davis, 1994) may well shape how our clients view themselves which may, in turn, impact upon the course of therapy.

Clinical psychologists therefore need to address the issue of how their work is perceived by their clients, by potential clients and by non-clients in order to improve

service efficiency (Furnham & Henley, 1988; Leong & Zachar, 1999). Not only does this have implications for how clinical psychologists work with each client individually, but also for how they 'market' themselves and their services within the public arena (Barker, Pistrang, Shapiro & Shaw, 1990; Hopson & Cunningham, 1995; Morrison, 1991). As a relatively young profession that is rapidly evolving, proliferating and diversifying, how, in fact, is clinical psychology perceived by the world outside the clinic walls?

The aim of the present study was to address this issue by exploring the meanings people construct and assign to the concepts 'psychology' and 'the psychologist', and how these meanings are related to the socio-cultural milieu within the UK at the end of the 20<sup>th</sup> century. The theoretical basis for the study is the social constructionist approach of social representations theory, which emphasises the reciprocal interdependence between society and the individual. The rationale for the study is that this reciprocal interaction generates meaning systems which fundamentally underpin the expectations of clients who are referred to psychology services. It is argued that these expectations, in turn, impact upon service efficiency and effectiveness. To improve service delivery, it is therefore proposed that clinical psychologists need to pursue a sophisticated understanding of the public's perspective. A social representational approach would argue that this requires acknowledgement of the extent to which such a perspective is constrained and shaped by historical and socio-cultural ideas circulating within the public's collective discourse.

This chapter aims to set the scene for the study. It begins by surveying what is known about the pattern of help-seeking for psychological issues within the population at large. This enables a consideration of how the public interacts with psychological



services. Secondly, the question of how the public thinks about psychology is examined, by reviewing the research into lay beliefs and theories regarding psychological help. Social representations theory is then outlined and introduced as a possible alternative framework for exploring these issues. This is followed by a consideration of the contemporary social milieu. This is in order to explore possible socio-cultural influences which might shape current public views on psychology. Finally, in the light of the literature reviewed so far, a more detailed explication of the rationale, aims and research questions of the study is presented, within a social representational framework.

### **PATTERNS OF HELP-SEEKING FOR PSYCHOLOGICAL PROBLEMS**

An indication of the pattern of the public's interactions with psychological services was obtained by reviewing the literature on help-seeking behaviour. Within the UK, one large national survey is particularly noteworthy for having utilised a quota sampling procedure to ensure demographic representativeness (Barker, Pistrang, Shapiro & Shaw, 1990). Only 16% of the 1040 respondents reported that they would seek help from a mental health professional if they had a personal difficulty or emotional problem (Barker et al, 1990).

An overview of the international help-seeking literature suggests that the findings of the UK survey seem to be broadly in line with those of other Western countries, such as Canada (Bland, Newman & Orn, 1997), Germany (Hoeger, 1995), Australia (Hopson & Cunningham, 1995; Rickwood & Braithwaite, 1994), Greece (Madianos, Madianou & Stefanis, 1993), South Africa (Stones, 1996) and the US (Veroff, Kulka & Douvan, 1981). The overall conclusion from these studies therefore seems to be that most people

would prefer not to seek professional help if they were suffering from psychological distress. For example, in one US study, only 46% of respondents reported that they would seek professional help for a persistent problem, and only 22% reported that, if they did so, they would choose a psychologist or psychiatrist (Veroff et al, 1981).

Furthermore, studies which compared the rates of such hypothetical help-seeking with actual help-seeking behaviour suggest that the percentage of people with psychological difficulties who actually do seek professional help can be substantially lower (Savaya, 1998; Veroff et al, 1981).

A comprehensive review of primarily US help-seeking literature concluded that the majority of psychologically distressed people do not seek professional help (Wills & DePaulo, 1991). As there is evidence that the Americans favour the use of mental health professionals more so than the British (deBarbot, 1977; Todd & Shapira, 1974), it seems reasonable to suppose that this pattern may be even more apparent in a British sample. This hypothesis concurs with the findings of the large UK survey cited earlier (Barker et al, 1990). What are the possible reasons for this?

Although there are external barriers to help-seeking for psychological issues, such as financial constraints and accessibility to services (Kushner & Sher, 1991), some researchers have suggested that these have declined over recent years (Wills & DePaulo, 1991). Other work has highlighted the importance of considering a range of both internal and external factors in order to understand patterns of help-seeking behaviour (Carpenter, Morrow, Del Gaudio & Ritzler, 1981; Morton, 1995; Orme & Boswell, 1991). Indeed, there is a growing body of literature testifying to the importance of internal factors such as expectations in initially influencing help-seeking behaviour (Leaf, Livingston,

Tischler, Weissman, Holzer & Myers, 1985; Leaf, Bruce, Tischler, & Holzer, 1987; Tinsley, Brown, de St Aubin & Lucek, 1984) and in subsequently impacting upon treatment process and outcome (Clinton, 1996; Faller, 1998; Fischer, Jome & Atkinson, 1998; Harris, 1994; Joyce & Piper, 1998; Ross et al, 1994; Walborn, 1996).

It is therefore suggested that psychological factors play a substantial part in shaping the pattern of help-seeking behaviour for psychological problems within the general population (Harris, 1994; Kushner & Sher, 1991). These factors include beliefs about, attitudes towards, and perceptions of, mental health professionals, such as psychologists. In order to build up a picture of how the public perceives psychology, it therefore seems pertinent to consider what the literature has to say regarding these psychological factors.

### **BELIEFS ABOUT PSYCHOLOGICAL HELP**

A number of instruments have been devised to investigate the components of people's beliefs about psychological help. Fischer & Turner (1970) constructed the Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS). This was piloted on a student sample of mixed type and age and was able to predict which respondents had sought such help.

Factor analysis of three samples indicated that there were four dimensions to having a positive attitude towards professional psychological help: recognition of the importance and usefulness of such help, lack of concern with potential stigma, confidence in mental health practitioners and interpersonal openness.

A similar instrument, the Thoughts About Counseling Survey (TACS), used a sample of college students and revealed two main factors, 'therapist responsiveness' (fears about therapist competence and professionalism) and 'image concerns' (fears of negative judgement by therapist or self for seeking treatment) (Pipes, Schwarz & Crouch, 1985).

These factors were replicated in a subsequent analysis using a modified version of the TACS, entitled the Thoughts About Psychotherapy Scale (TAPS) (Kushner & Sher, 1989). This revealed a third factor labelled 'coercion concerns' (fears about being pushed to think, do or say things related to their problem in a new way).

A multifaceted construct termed 'treatment fearfulness' was therefore postulated as a psychological barrier to help-seeking for psychological problems (Kushner & Sher, 1991). These authors suggest that this incorporates any or all of a number of aversive expectations associated with mental health services. These include fear of change and/or coercion, fear of embarrassment through having to discuss intimate issues, and fear of being negatively judged by others, i.e. stigma. In addition, and of particular relevance to the present study, is the authors' suggestion that an aspect of the barrier to help-seeking is due to fears involving treatment stereotypes, such as the belief that therapists are incompetent, or that they hospitalise and drug all their clients.

Building on the work outlined above, one study, using a non-clinical mature student sample, has investigated the extent to which self-rated help-seeking intentions for a personal or emotional problem could be predicted from psychological distress, gender, attitudes toward psychological help-seeking (using the ATSPPHS), and treatment fearfulness (using a modified version of the TAPS) (Deane & Todd, 1996). The modified

TAPS used in this study included a fourth subscale entitled 'social stigma concerns' (fears of being judged negatively by friends, family or employers for seeking treatment) (Deane & Chamberlain, 1995). The results suggest that the four predictors accounted for 50% of the variance in help-seeking intentions. However, the only significant unique predictors were attitudes toward psychological help-seeking and female gender.

With attitudes toward psychological help-seeking as the dependent variable, psychological distress, gender and the four treatment fearfulness subscales accounted for 29% of the variance in attitudes. However, only the 'social stigma concerns' subscale was uniquely predictive of attitudes.

Taken together, the body of work on treatment fearfulness and its components, using the TACS and the TAPS, appears to be broadly consistent with the work on attitudes towards seeking professional psychological help, using the ATSPPHS. This suggests that the emergent themes are fairly robust. Furthermore, overall there seemed to be one theme which appeared most consistently influential in shaping people's beliefs and help-seeking behaviour. This theme was the association of psychological help with being stigmatised. Several groups of authors have suggested that the risk of being stigmatised by others is one of the main reasons for not seeking psychological help (Deane & Chamberlain, 1995; Deane & Todd, 1996; Kushner & Sher, 1991; Leong & Zachar, 1999; Socall & Holtgraves, 1992).

In addition, as well as the attitude questionnaire studies outlined above, there is also a body of experimental evidence supporting the contention that recipients of psychological help are stigmatised. For example, one study showed that inducing the belief that someone has sought professional psychological help is sufficient for people to

react to them in a stigmatising way (Sibicky & Dovidio, 1986). It seems, then, that the mere belief that someone is seeing a therapist can result in others treating them more negatively (Harris, 1994). Furthermore, other experimental work shows that when participants believed, erroneously, that they were being perceived as clients of psychological services, their behaviour was judged to be less positive. This suggests that people feel greater discomfort and behave differently purely as a result of believing they possess a status that may be derogated by others (Harris, 1994).

Overall, then, the idea that stigma is associated with receiving psychological help has emerged as a common theme across many different areas of empirical work (e.g. Deane & Chamberlain, 1995; Fischer & Turner, 1970; Harris, 1994; Leong & Zachar, 1999; D.Rose, 1996; Socall & Holtgraves, 1992; Stefl & Proserpi, 1985).

Another body of work, produced by Tinsley and colleagues, has explored the link between help-seeking behaviour and expectancies about counselling in a US undergraduate population (Tinsley et al, 1984; Tinsley, de St Aubin & Brown, 1982; Tinsley & Harris, 1976; Tinsley, Workman & Kass, 1980).

Early work by this group suggested that, although the students expected counsellors to be genuine, accepting and expert, they were less optimistic regarding outcome, or the level of understanding counsellors would achieve (Tinsley & Harris, 1976). The researchers concluded that this might indicate a belief that counselling could be helpful, coupled with a doubt that it could ever be helpful to them. Although this work focused on counselling, it seems reasonable to postulate that such findings may also be applicable to people's views about psychology.

Tinsley's group subsequently developed the Expectancies About Counselling questionnaire (EAC) (Tinsley et al, 1980). The authors believe this measures four conceptually distinct classes of expectancies: client attitudes and behaviour; helper attitudes and behaviour; helper characteristics; characteristics of the counselling process and outcome.

One study, using a brief version of the EAC, is particularly pertinent as it explored people's beliefs about different types of psychological help provider. This study investigated differences in expectancies held by undergraduate volunteers for a range of different possible help providers (Tinsley et al, 1984). The results indicated that participants expectancies of, and tendencies to seek help from, did not differ significantly between counselling psychologists, clinical psychologists and psychiatrists.

However, on 7 of the 18 EAC items there were significant differences between participants expectancies of clinical and counselling psychologists, as compared to counsellors (Tinsley et al, 1984). In this study, then, participants expected psychologists to be more confrontative and directive than counsellors, whilst they expected clients of psychologists to be more motivated and open than clients of counsellors. In addition, they expected the process of the helping sessions to be more characterised by concreteness and use of immediacy when the helper was a psychologist, compared to counselling. Interestingly, although they had significantly greater expectations for a beneficial outcome with a psychologist compared to with a counsellor, their expectancy that psychologists would be more expert did not quite reach statistical significance.

As regards people's beliefs about different psychological help providers, then, these results suggest that, at least in this US undergraduate sample, people do not carry

homogeneous beliefs regarding differently titled psychological help providers, but that they do tend to view psychologists as being more similar to psychiatrists than they are to counsellors.

Overall, then, evidence from studies using the ATSPPHS, the TACS, the TAPS and the EAC highlights a variety of important components of people's beliefs about psychological help and its providers. These include a number of concerns: the utility value of psychological help, the possible stigma associated with it, its potentially intrusive and coercive nature, and the competence and distinctiveness of different help providers. This body of work undoubtedly sheds some light on the components of a 'psychology-friendly' attitude and on the extent to which people perceive psychologists as a distinct entity. However, the structured self-report nature of the studies means that they are limited, in that they do not tell us directly about people's conceptions of psychology and psychologists. Accessing the conceptions that drive people's attitudes involves elucidating their underlying constructs in an open-ended manner, rather than presenting respondents with a prepared list of items to rate. For example, Fischer & Turner's ATSPPHS contains items such as :-

*"I would rather be advised by a close friend than by a psychologist, even for an emotional problem"*

Participants' answers to this are of relevance to their orientation towards psychology and psychologists. However, it is also of interest what views they hold of the



nature of psychology and psychologists which have led them to respond to such items in the way that they do.

Furthermore, people's actual behaviour relative to a specific attitude object, such as 'the psychologist', may be motivated by more covert beliefs. These may not be openly expressed, for example, due to a social desirability bias or to lack of conscious awareness (Wright & Davis, 1994). It has thus been argued that in order to inform people effectively about a phenomenon, it is more efficient to have some idea about the underlying constructs which may be driving people's behaviour and their attitudes, both overt and covert. The rationale for this is that information given to people regarding a phenomenon will only be effectively incorporated into their belief system if it is presented in such a way as to modify the underlying constructs that generate the attitudes (Joffe, 1996a). This argument has significant implications for how services market themselves to potential clients. Psychologists could utilise insights of this nature in planning appropriate and effective marketing of services, both directly to potential clients and indirectly through public awareness (Cepeda-Benito & Short, 1998). It could therefore be argued that there is a need for research which is able to complement the self-report literature by attempting to tap into the domain of the underlying constructs driving attitude formation and behaviour.

### **LAY THEORIES ABOUT PSYCHOLOGY**

It seems reasonable to suppose that the underlying constructs about psychology and psychologists which drive participants' responses in the type of questionnaire studies outlined above will be related to the theories that they hold about the world. These ideas

have been termed 'lay theories'. The existing literature on lay theories of how to overcome psychological difficulties may therefore give some indication as to people's constructs regarding psychology and psychologists.

Furnham and colleagues have conducted an ongoing series of studies relevant to a consideration of lay theories about psychology (Furnham, 1993 & 1997; Furnham & Henley, 1988; Furnham & Rees, 1988; Furnham & Wardley, 1990 & 1991; Furnham, Wardley & Lillie, 1992). A meta-analysis of these studies has enabled comparisons to be made between lay views regarding cures for 22 different problems, each of which could be viewed as having a psychological component (Furnham & Hayward, 1997). The non-clinical, primarily student sample endorsed getting professional help as important in overcoming almost all 22 problems. In addition, the factor structure for all the problems was very similar, generally consisting of 'Inner Control' (willpower), 'Receiving Help', 'Understanding' (the nature of the problem) and 'Social Consequences' (the extent and nature of these).

These findings suggest that lay people acknowledge the potential usefulness of professional intervention in overcoming psychological difficulties. However, this work is not able to reveal people's conceptions regarding the nature of such interventions, of the people that receive them, or of the agents that supply them.

An overview of all 22 problems included in the meta-analysis (Furnham & Hayward, 1997), plus another comparable study on lay beliefs about cures for 5 common DSM-IV anxiety disorders (Furnham, 1997) suggests that the relative importance assigned to each factor varied for different problems, e.g. inner control was prioritised for gambling (Furnham & Henley, 1988), whereas receiving help was prioritised for

schizophrenia. This implies that people in a non-clinical sample consider receiving help to be of differential usefulness, depending on how they conceptualise the nature of the problem.

However, the observed pattern from these studies does not necessarily concur with how professionals might view the usefulness of receiving help for different problems (Furnham & Hayward, 1997). These findings are supported by other work which suggested that lay respondents were able to formulate their own opinions as to the differential usefulness of a range of therapies and the prognosis for different problems (Furnham & Wardley, 1991), but that the pattern of their opinions seemed to differ compared to a sample of clinical psychologists (Furnham et al, 1992).

The work of Furnham and colleagues seems to indicate that people believe different problems require different types of help. The work of Tinsley and colleagues outlined earlier indicates that people believe different types of psychological help provider function in different ways. Other work suggests that lay people who are current psychiatric service users endorse psychological theories of aetiology and intervention more so than socio-economic or organic theories (Pistrang & Barker, 1992). However, all these studies beg the question as to how the public actually construe potential help and its providers. In other words, why do people hold these beliefs?

Some evidence has been put forward to suggest that lay respondents have a generally positive attitude towards psychotherapy, together with a fairly realistic, if somewhat variable, appraisal of what actually occurs during therapy (Furnham & Wardley, 1990; Wong, 1994). However, these conclusions are tempered by the fact the questionnaire items were generated at least partly by consulting text books and exponents

of psychotherapy. This may have resulted in a set of items which did not match the types of attitude statement participants would have generated themselves, particularly if their knowledge of the subject matter was limited. This may therefore have resulted in intelligent guesswork and a social desirability bias amongst the primarily student sample, rather than representing a reflection of their underlying attitudes and beliefs. Moreover, this type of study carries the same limitations outlined earlier with regards to the attitude questionnaire studies, in that it does not access the root of people's attitudes or their underlying conceptions of psychology and the psychologist.

Overall, however, it does seem reasonable to conclude that there is some evidence to suggest that the public do have views on psychology-related issues, and that these may differ from the views of professionals from within the field. Interestingly, there is also evidence to suggest that even students electing to read psychology at university carry many misconceptions regarding the field, such that there is no apparent correlation between interest in and knowledge of psychology (Furnham, 1993; Furnham & Rawles, 1993). Moreover, it appears that even some British health care professionals have only limited knowledge about the skills and services on offer from clinical psychologists (Osborne-Davies, 1996). Public confusion about the possible role of clinical psychology, along with a degree of negativity, has also been noted in Australia (Hopson & Cunningham, 1995) and in South Africa (Stones, 1996).

However, the question still remains as to what the actual nature and content of people's views might be regarding psychology and its practitioners, and how this might impact upon the effectiveness of clinical practice (Cepeda-Benito & Short, 1998). In general it could be argued that the self-report literature has provided useful insights from

the quantitative tradition which might be complemented by a consideration of these issues in a richer, more qualitative way. This then opens up the possibility of tapping into the constructs which drive attitude formation (Joffe, 1996a). An appreciation of these will facilitate psychologists' understanding of the origins of client expectancies, and thereby address the issue of appropriate marketing of psychological services (Hopson & Cunningham, 1995).

### **AN ALTERNATIVE APPROACH**

It has been argued that research into the public's conceptualisations of psychology and the psychologist could be of benefit in enabling efficient promotion and uptake of services within the NHS. There are a number of problems with the existing literature related to this aim. One problem has already been raised in the context of the studies outlined earlier, namely that traditional self-report approaches which present participants with a prepared list of items to rate may well not be accessing the underlying concepts that drive people's attitudes. Instead, participants may effectively feel forced to construct responses which they themselves would not have generated (Eagly, Mladinic & Otto, 1994).

In addition, the strength of the conclusions that can be drawn from such work in terms of generalisability is compromised by the fact that much of the work is carried out using samples which primarily consist of students. Not only does this mean that the samples are non-representative of the general public, but it is often unclear as to the nature of the research set-up, such as the extent to which the participants chosen responses might reflect a social desirability bias. One possible example of this might be if

the research is being conducted by the participants' own course tutor. Issues such as these regarding participants in quantitative work are seldom addressed openly (Banyard & Hunt, 2000).

Furthermore, many studies draw conclusions from multiple analyses without necessarily addressing the issues of statistical power and Type I errors, which further compromises the validity of the results. Moreover, generally there has been little emphasis on a theoretical framework to drive the research and with which to evaluate the results.

In addition to these methodological issues, the existing studies can be criticised from an epistemological perspective. In order to explicate why this is so, it is necessary to consider the philosophical underpinnings of different approaches to social psychological research.

The traditional self-report attitude questionnaire methodology used in all the studies outlined above exemplifies mainstream Cartesian individualist social psychology (Joffe, 1996a; Purkhardt, 1993). This takes as its starting point the view that society is composed of individuals on whom the environment acts. Attitudes are seen as features of these individuals which drive their behaviour. This reductionist view, in which people are assumed to perceive external 'truths' in order to form attitudes about the world, is challenged by social constructionist approaches (Gergen, 1999).

Social constructionists argue instead that people actively construct their own worldview, based on their perceptions, so that it makes the maximum amount of sense for that individual and serves a particular purpose for them. In other words, because all that people can access is their perceptions of the world, an objective reality is ultimately

unknowable (Burt & Oaksford, 1999). The crucial point with regards to the argument being presented here is that this process of constructing a worldview is shaped by concepts, ideas, symbols and images which are circulating within the social realm of the day (Joffe, 1999). These are therefore specific to the individual's particular socio-cultural and historical context (Potter, 1996).

Social constructionist approaches thus take the stance that reality is not something external to the observer and immutable, waiting to be discovered, but instead versions of reality are constructed to serve particular functions within a particular context (Burt & Oaksford, 1999; Gergen, 1999). The 'knowledge' with which this is done is thus seen as socially, historically and culturally specific, developed and sustained by social processes. Social constructionist approaches are therefore in line with a Hegelian epistemological stance which emphasises the 'social' aspects of society, and the interdependence between individual and society in a continuously evolving dynamic (Purkhardt, 1993). This interdependence is difficult to conceptualise using traditional pre-Hegelian modes of thinking which define 'social' and 'individual' as independent concepts (Markova, 1996). Traditional attitude questionnaire research exemplifies this pre-Hegelian epistemology, with its clear distinction between the social environment and the individual.

One particular approach within the social constructionist tradition focuses on the idea that social groups share concepts or constructs called 'social representations' which individuals then use to understand their social world and from which they derive their attitudes. Attitudes are thus seen not as something to be picked up from an external world, but instead as phenomena that are built up, and social representations are seen as

the devices that do the building (Potter, 1996). This approach is called social representations theory.

### **AN OVERVIEW OF SOCIAL REPRESENTATIONS THEORY**

Social representations theory developed as an approach to the systematic study of common sense thinking (Moscovici, 1984). More recently, it has been referred to as a paradigmatic approach to thinking about social and psychological processes simultaneously (Wagner, 1996). It therefore challenges the epistemology of methodological individualism because it does not conceptualise subject and object as functionally separate (Purkhardt, 1993; Wagner, Duveen, Farr, Jovchelovitch, Lorenzi-Cioldi, Markova & Rose, 1999).

Social representations theory refers not only to the content of the ideas circulating in a given society at a given time, but also to the specific processes which shape this content. It proposes that three key processes are at work as social representations of a phenomenon develop. Each of these processes focuses on a different type of socio-cultural force which interacts with an individual's thinking, thereby shaping his/her representations of the phenomenon. The first of these processes is deemed to be the transformation of ideas from society's 'experts' into lay thinking. With many new phenomena in Western cultures this generally amounts to the dissemination of scientific knowledge via the mass media. The other two processes described by social representations theory – 'anchoring' and 'objectification' - focus on the ways in which individuals integrate new ideas by bringing to bear salient related concepts already existing within the culture.



‘Anchoring’ refers to ways in which new and unfamiliar ideas are rendered familiar. This can be seen as somewhat analogous to the Piagetian concept of cognitive assimilation, but with the important caveat that it is not seen as an individual process. Instead, social representations theory very much emphasises the role played by existing socio-cultural ideas in providing a familiar concept which can be used as a classificatory category, or ‘anchor’, for the new phenomenon (Joffe, 1999; Purkhardt, 1993). This functions to remove the threat associated with unfamiliarity, as the new phenomenon is viewed as sharing similar characteristics to the anchor. A prime example of anchoring is to be found in Moscovici’s (1976) seminal study on the dissemination of psychoanalytic concepts into lay thinking in France. He found that Catholics conceptualised psychoanalysis as a form of the confessional. Their use of this familiar and understood concept as an anchor served to lessen their anxieties regarding the new, and otherwise mysterious, cultural phenomenon of psychoanalysis.

The process of ‘objectification’ works alongside anchoring. Objectification is an attempt to concretise the abstract. It therefore overlaps considerably with the idea of symbolisation. Symbols are cultural heuristics which are able to trigger off a complex and abstract combination of thoughts, ideas, images and emotions which would be difficult to verbalise. Their meaning is therefore idiosyncratic to the specific socio-cultural and historical context. Objectification and symbolisation therefore function to translate abstract concepts into images or metaphors which are part of the cultural heritage and can be understood at a glance by members of the group. Examples of such images include the crucifix as a symbolisation of Christian ideology, the swastika as a symbolisation of Nazi ideology and the more recent red ribbon as a symbolisation of the fight against AIDS. It

requires only a brief consideration of these potentially emotive examples to realise that each of these symbols will have a different meaning, depending on the socio-cultural group to which an individual is affiliated.

It is argued that a core motivation for the development of particular representations in preference to others is in-group and self-identity protection (Joffe, 1999; Wagner et al, 1999). The anchors and symbols chosen for a new phenomenon are therefore likely to reflect in-group values, so that the identities to be protected will shape the representations that evolve. This has been exemplified by work on the social representations of the origins of AIDS (Joffe, 1996a, 1996b & 1999). Different cultural groups, Europeans and Africans alike, were shown to carry social representations of the HIV virus as having emerged in parts of the world other than their own. For each group, this functioned as a way of distancing themselves from the risk of threat or blame associated with this deadly virus. In each case, this enabled them to maintain a representation of themselves as a 'safe' group.

Social representations theory, then, conceptualises the development of an individual's representations of a new phenomenon as the outcome of the impact of a variety of forces – expert ideas disseminated via the mass media, the bringing to bear of knowledge about existing related concepts and their use as anchors, and the incorporation of culturally-relevant symbolic meanings (Joffe, 1999). The social milieu of an individual is thus seen to shape and be shaped by social representations. One implication of this is the extent to which the social representations within a culture at a given time constrain the belief system of an individual (Markova, 1996).

This fundamental interdependence between individual and society is overlooked by traditional mainstream cognitive and information-processing accounts which have dominated social psychological research into knowledge, attitudes and beliefs (Joffe, 1996a; Purkhardt, 1993). In such approaches, individual representations are viewed as essentially cognitive and are effectively severed from their socio-cultural context and social function. An individual is thus conceptualised as possessing a representation in the mind which stands for some object 'out there' in an objective external reality.

In contrast, social representations are seen as comprising an inextricably bound network of cognitions, emotions and actions (Jovchelovitch, 1996) which circulate in the collective discourse of a group, serving a function for the group members (Wagner, 1996). A social representational perspective would therefore argue that it is precisely these downplayed aspects of socio-cultural context and function that need to be understood and incorporated to further our understanding of the forces which shape people's views and behaviour. It is clear from decades of traditional attitude questionnaire research that an alternative approach is indeed desirable in view of the robust finding that the correlation between people's responses on such questionnaires and their actual behaviour is notoriously poor (Joffe, 1996a; Petty & Krosnik, 1995; Wicker, 1971).

Having outlined the basic tenets of a social representational approach to social psychology, how can such a perspective contribute to understanding public views on psychology? In order to build on the findings from the traditional self-report attitude questionnaire studies, it is proposed that psychologists must pursue a sophisticated understanding of the public's perspective in a way that acknowledges the societal forces

that have shaped it. For example, mainstream social psychological studies of public knowledge about psychological help have described the public as “ignorant” regarding psychology and psychologists (e.g. Furnham & Wardley, 1990; Hopson & Cunningham, 1995). This is termed a ‘deficit model’ in the literature on the public understanding of science (Bauer & Gaskell, 1999).

In contrast, the originator of social representations theory has argued that a key aspect of human experience relates to making meaning, rather than exchanging information (Moscovici, 1984). Social representations theory therefore proposes that, rather than viewing the public as ignorant, it is more helpful to consider them as co-constructing a meaning system which has emerged from the historical and cultural symbols dominating the society in which they live (Wagner et al, 1999). Representations are therefore not seen as inaccurate or biased, but instead as fulfilling functions within the social milieu (Bauer & Gaskell, 1999; Joffe, 1999; Wagner, 1996). These functions may operate at different levels of conscious awareness (Joffe, 1999; Potter, 1996). Social representations theory thus focuses on the interplay between conscious and non-conscious processes (Markova, 1996), in contrast to other work on lay beliefs.

The crucial difference, then, is that social representations theory is essentially a theory of the emotional and symbolic meaning-making aspects of human experience within a specific context, rather than of rationalist information-processing. Such alternative approaches have evolved because it has been argued that the mind-as-machine metaphor within mainstream psychology is of limited usefulness in helping us to understand the richness of human experience (Joffe, 1999). This suggests that an exploration of the meaning making systems inherent in social representations of

psychology could provide a richer understanding of the complex forces that direct people's thinking and behaviour with regard to psychological services.

Social representations theory construes the attitudes by which individuals live their lives as products of their social representations of the attitude object which may be operating outside of conscious awareness (Joffe, 1999; Potter, 1996). In contrast, the attitudes that people can endorse in self-report studies are first pre-determined by the researchers and then consciously selected by the participants. It is therefore argued that the representations which drive people's actual behaviour are not necessarily accessed by this type of research. This argument gives a possible explanation for the poor correlations commonly observed between responses on attitude questionnaires and people's actual behaviour (Petty & Krosnik, 1995; Wicker, 1971). The relevance of this to the present discussion is that poor attitude-behaviour correlations have been observed in studies comparing hypothetical and actual help-seeking for psychological difficulties (Savaya, 1998; Veroff et al, 1981).

This, then, is the crux of an epistemological critique of traditional self-report approaches to researching people's views on psychological services. Although checklist measures may be seen as simpler to analyse (Geer, 1991), they are unlikely to tap this underlying level of social representations. This is because this may well not be readily accessible to conscious awareness and/or may not generate socially desirable responses (Haddock & Zanna, 1998; Joffe, 1999). It follows from this that, in order to pursue an understand of how the public views psychology and psychologists, their social representations of these concepts must be accessed in an open-ended manner. This allows

for the natural emergence of people's idiosyncratic meaning systems. To date, no study has attempted to do this.

In addition, it is proposed that social representations theory is a particularly appropriate framework for a study on how people view psychology and psychologists. This is because of the special emphasis in social representations theory on how social groups absorb and make meaning out of new phenomena (Bauer & Gaskell, 1999). It would seem that the phenomena of psychology and the psychologist within a predominantly Western UK culture at the turn of the millennium fits well into such a category. Few would dispute that there has been an explosion of interest in psychology in recent years and that society is becoming increasingly 'psychologised' (N.Rose, 1996). It seems relatively common nowadays for all branches of the media to feature psychology-related items and discussions and to seek the opinions of psychological 'experts' on a wide range of issues. In addition, psychology is becoming an increasingly popular choice at 'A' level and at university, as well as being increasingly demanded within the NHS (Roth, 1998).

From a social representational perspective, this suggests that the concept of 'psychology' has moved beyond the expert realms in which it originated, and that ideas concerning it and its practitioners have been disseminated to the outside world of the lay public via the media. According to social representations theory, the media will not only have initiated the process whereby lay people begin to form their social representations of 'psychology' and 'the psychologist', but will also have determined the foundations of these representations by the way in which it presents these phenomena. However, as time has gone on, a dynamic of mutual influence will have emerged (Purkhardt, 1993), such

that the increased public profile of psychology in the media will both shape and be shaped by the public's social representations of psychology.

At this point in history, then, as public and media interest in psychology has never been higher, it seems timely to explore just what social representations of psychology have been forged in the public domain. A social representational approach would argue that it is out of the context of these current social representations that the public's beliefs and behaviour regarding psychology services will emerge because "social representations are the common senses of social milieus" (Bauer & Gaskell, 1999, p.179). The argument presented here proposes, therefore, that client expectancies will evolve directly as a product of public social representations of psychology, and that these expectancies affect service effectiveness and efficiency.

### **A CONSIDERATION OF THE CURRENT SOCIO-CULTURAL MILIEU**

It is useful to consider at this juncture what aspects of contemporary society might be expected to contribute to current social representations of psychology. Firstly, there is a growing body of literature on representations of madness and mental illness, both historical and contemporary (e.g. deRosa, 1987; Jodelet, 1991; D.Rose, 1996; Wahl, 1995). Social representations theory would argue that this rich history of socio-cultural ideas around a phenomenon such as madness forms the basis for modern day social representations. This is because such ideas become embedded as part of the cultural heritage of the society, and as such are shared at a social level. It therefore seems reasonable to suppose that the public may associate psychology with madness. Current

social representations of psychology, and thus beliefs about psychology, may well be shaped by current and past representations of madness and psychological distress.

Different representations of madness have been constructed at different time-points in history according to the prevailing beliefs of the period. However, what has remained consistent is the image of madness as a form of deviance which society feels the need to identify in order to achieve a distinction between the 'sane' and the 'insane' (Gilman, 1988; Morant, 1998). Over the years the nature of this deviance has transmuted from representations of the 'madman' as a mysterious, evil and monstrous figure, through criminalisation of the insane, such that they were viewed as dangerous and deserving of incarceration, to a progressively more medicalised model of madness, in which the insane are conceptualised as being sick (deRosa, 1987). Social representations theory emphasises the historical antecedents of people's representations. It would therefore predict that, to the extent that people associate psychology with madness, current representations of psychology might well be imbued with any or all of these historical precursors.

As social representations theory tends to focus on the dissemination of representations via the mass media, it seems pertinent to consider what media issues might influence current social representations of psychology. One such issue is the relatively recent social policy of 'Care in the Community'. This emerged most strongly following The NHS and Community Care Act 1990 and has inspired, and is continuing to inspire, much media interest. For most members of the public, their contact with issues relating to this policy is likely to be indirectly, via the media coverage. In actuality, most analyses seem to suggest that media reporting of community care stories is largely



negative, such that the recipients of community care are represented as dangerous, violent and to be feared (D.Rose, 1996). This suggests that such media representations have been driven by the more sensationalist aspects of the historical representations of madness and mental illness outlined earlier. To the extent that the public is likely to associate psychology with mental illness, such media images of the implementation of 'Care in the Community' would be expected to impact upon social representations of psychology.

Another psychology-related phenomenon which is becoming increasingly common in the media is the portrayal of therapy and therapists. This is apparent in recent television releases, such as 'Ally McBeal' and 'Frasier', and films, such as 'Analyze This', 'Sixth Sense' and 'Good Will Hunting'. Social representations theory emphasises the influential role of these kinds of mass media in shaping social representations of phenomena (Bauer & Gaskell, 1999). In relation to this, one study concluded that in 207 American films from 1902 to 1986, 44% of therapists were portrayed as incompetent and 22% as nefarious (Schneider, 1987). To the extent that the public associate psychology with therapy, such television and film portrayals of therapy and therapists are likely to impact upon social representations of the psychologist.

In considering possible contributions to current social representations of psychology and psychologists, the discussion so far has been suffused with a predominantly negative theme. It is argued that this reflects the historically consistent pattern of the stigmatising of phenomena that Western cultures have been taught to fear, of which 'psychic disintegration' is one example (D.Rose, 1996). This fear of psychic disintegration is suggested as the driving force behind the theme of stigma which is pervasive throughout the literature reviewed so far (e.g. Deane & Chamberlain, 1995;

Deane & Todd, 1996; Fischer & Turner, 1970; Harris, 1994; Kushner & Sher, 1989 & 1991; Leong & Zachar, 1999; Pipes et al, 1985; Sibicky & Dovidio, 1986)

There is therefore a substantial body of converging evidence to suggest that people view mental health issues and attendance at therapy as inherently threatening in some way. The literature on response to risk proposes that people defend themselves against threat by locating its source as being within others (Joffe, 1999). The discussion so far suggests that the public may associate psychology with threat. If so, social representations of psychology may explicitly or implicitly make reference to it as an entity located with the 'Other', rather than with the self or peers (Gilman, 1988), as a way of defending against the threat it poses. This would be an analogous position to one developed with regards to AIDS, in which AIDS tends to be associated with out-groups and deviance (Joffe, 1996a, 1996b & 1999).

Previous work therefore seems to suggest that social representations of psychology and the psychologist may be oriented around a response to stigma. This suggests that positive connotations concerning clients of psychology services may not be incorporated into social representations of psychology. Instead, it seems more likely that the representations will be infused with stigma-related meaning. Any data which challenge this are therefore of particular interest as they may reflect a newly emerging trend in public thinking which is not apparent in the existing literature (Morant, 1998). Indeed, the contemporary 'psychologising' of society (N.Rose, 1996) suggests that psychology may be increasingly seen as fulfilling a positive function. If so, this may be reflected within the public domain in the emergence and circulation of positive social representations of psychology and the psychologist.

A recent sociological analysis of “the rise of the expertise of human conduct” (N.Rose, 1996, p.85) suggests that, as far as the public is concerned, the social role of psychology is becoming ever more apparent. This analysis proposes that psychologists are increasingly viewed as carriers of expertise who can bestow help in the face of life’s tragedies and who impart a language with which to describe human experience (N.Rose, 1996). Current social representations of psychology may therefore incorporate positive concepts of the utility of the psychologist’s expertise in alleviating distress and facilitating personal growth (Harris, 1994).

Finally, it seems there are several bodies of knowledge which the public might use to anchor their representations of psychology. Firstly, if social representations of psychology link it to mental illness, the public may view psychology as a branch of medicine. However, in addition, Moscovici’s (1976) classic study demonstrated that the public in France had already developed social representations of psychoanalysis as long ago as the 1950s. It therefore seems plausible that a contemporary UK public may also have absorbed psychoanalytic ideas and that these may, in turn, be used in representations of psychology instead of, or as well as, medical anchors. In contrast to this, it has also been suggested that psychology might be viewed as an alternative to traditional medical concepts (Hopson & Cunningham, 1995), and so the new wave of ideas about alternative therapies and complementary medicine might generate other possible anchors.

## **A SOCIAL REPRESENTATIONAL PERSPECTIVE ON THE LITERATURE**

The literature on people's views about psychology-related issues can now be revisited and re-considered in the light of a social representational framework. In terms of social representations theory, then, it is proposed that social representations shape :-

- people's responses on questionnaire measures of their attitudes towards psychological help, e.g. the Attitudes Towards Seeking Professional Psychological Help Scale (Fischer & Turner, 1970), the Thoughts About Counseling Scale (Pipes et al, 1985), the Thoughts About Psychotherapy Scale (Deane & Chamberlain, 1995; Kushner & Sher, 1989), and the Expectancies About Counselling Scale (Tinsley et al, 1980)
- people's beliefs about psychological help providers (Schneider, 1987; Tinsley et al, 1984)
- lay theories about psychological problems, their aetiology and their treatment (Furnham & Hayward, 1997; Furnham & Wardley, 1991; Pistrang & Barker, 1992)
- people's beliefs about what happens during psychological therapy (Furnham & Wardley, 1990; Wong, 1994)
- people's views on psychological distress (deRosa, 1987; Jodelet, 1991; Leong & Zachar, 1999; D.Rose, 1996; Wahl, 1995)
- people's responses to clients (Harris, 1994; Jodelet, 1991; Sibicky & Dovidio, 1986)
- people's responses to becoming a client (Deane & Chamberlain, 1995; Deane & Todd, 1996; Harris, 1994; Kushner & Sher, 1991; Leong & Zachar, 1999)

The results of the studies mentioned have provided insight into how people might construe psychology, its practitioners and its clients. However, this work could usefully be complemented by an in-depth exploration of the underpinnings of people's self-report

responses. It is proposed that a social representational approach provides an appropriate theoretical framework for this. This is because it encompasses a simultaneous consideration of individuals' beliefs and attitudes, the socio-cultural and historical milieu in which they have arisen, and the extent to which each of these constrains the other. A social representational approach therefore builds on existing work because it incorporates:

- an emphasis on socio-cultural context
- the notion that existing socio-cultural phenomena form the anchors for social representations of new phenomena
- the view that social representations drive attitudes and behaviour

In other words, because social representations are derived from existing socio-cultural concepts, it is the socio-cultural context that is indirectly responsible for the attitudes people hold, and, therefore, only a limited understanding of people's views on psychology can be gained if the socio-cultural milieu is not included in the investigation.

Research driven by social representations theory makes the assumption that social representations of new phenomena evolve by anchoring the unfamiliar to an already existing representation, and that the representations available will depend upon the cultural and historical heritage of the particular society. Social representations of psychology might thus be linked to social representations regarding psychological distress and the people who seek professional help for it (e.g. deRosa, 1987; Jodelet, 1991; D.Rose, 1996), beliefs about causes and cures for psychological problems (e.g. Furnham & Hayward, 1997; Matschinger & Angermeyer, 1996), ideas of alternative therapies (e.g. Hopson & Cunningham, 1995), ideas about the nature of psychological

help (e.g. Furnham & Wardley, 1990; Tinsley et al, 1984), its providers (e.g. Schneider, 1987) and its utility (e.g. Harris, 1994; N.Rose, 1996), ideas about psychoanalysis (e.g. Moscovici, 1976), and ideas associating psychology with 'The Other' (e.g. Gilman, 1988).

### **RATIONALE FOR A QUALITATIVE APPROACH**

Since the essence of a social representational approach is the accessing of an individual's meaning system, this must be reflected in the research methodology chosen. The recent and ongoing proliferation of research methodologies within the social sciences has led to considerable debate as to the relative merits of different approaches. In general, there appears to be an emerging consensus that qualitative research can be of greatest value in addressing questions concerning the activity of making meaning of experiences, whilst taking into account how they are embedded within specific socio-cultural contexts (Elliott, Fischer & Rennie, 1999; Yardley, 2000). Since the aim of the present study was to access such meanings, it is therefore most appropriate to use a qualitative approach, particularly as there are now convincing arguments for the utility and increasing rigour of such work (Burt & Oaksford, 1999; Elliott et al, 1999; Haddock & Zanna, 1998; Yardley, 2000).

It has been argued that the social representations which people use to impute meaning within their social world are likely to operate, at least in part, outside of conscious awareness. The implication from this is that a list of self-report items is likely to produce results that contain a degree of artificiality and questionable ecological validity (Eagly et al, 1994). One type of approach which goes some way towards

circumventing this problem is content analysis of responses to open-ended questions in which people's narrative is allowed to flow relatively freely. The pathways of meaning that emerge are therefore more likely, often not consciously, to provide a richer explication of the underpinnings of a person's meaning system and that of their society (Joffe, 1999). Even researchers from a more mainstream attitudinal research perspective have argued that content analysis of open-ended measures can enrich understanding of the forces that drive people's beliefs and behaviour (Eagly et al, 1994; Haddock & Zanna, 1998).

In relation to the present study, analysing responses to open-ended questions facilitates the elucidation of anchors of psychology other than the ones which have already been suggested. This would not be possible using a structured questionnaire because this does not allow for the emergence of unexpected ideas (Kunkel & Williams, 1991).

Furthermore, a structured questionnaire requires participants to respond to ideas that they themselves may not have generated spontaneously. This masks the fact that certain ideas may be absent from participants' own meaning systems. In contrast, analysing responses to open-ended questions allows for the emergence of participants' own natural pathways of meaning, in which certain ideas or themes may not be present. In terms of clinical relevance, it is this absence or scarcity of particular ideas that may be of considerable significance (D.Rose, 1996).

## **AIMS OF THE STUDY**

It has been argued that it is necessary to tap into the meanings the public assigns to the concepts of psychology and the psychologist, in order to have a sophisticated understanding of client expectancies regarding psychological services. A rationale for the advantages of accessing the public's social representations of psychology in an open-ended manner has been put forward. However, in order to conduct a meaningful study of this kind it is necessary to make explicit empirically and/or theoretically guided decisions about how to sample 'the public'. Such decisions should be made by considering where group differences in social representations might be hypothesised to occur, in order to ensure a meaningful segmentation of the overall social milieu termed 'the public' (Bauer & Gaskell, 1999).

Findings from several lines of work suggest that different age cohorts may hold different beliefs about help-seeking (Wills & DePaulo, 1991), and mental health in general (Leaf, Bruce, Tischler & Holzer, 1987), and that treatment fearfulness is likely to vary with age (Kushner & Sher, 1991). In addition, other work raises the more specific possibility that there may be age differences in beliefs about psychology (Hopson & Cunningham, 1995), psychotherapy (Furnham & Wardley, 1990) and counselling (Kunkel & Williams, 1991). Moreover, social representations theory itself emphasises the importance of people's historical experiences in shaping their representations of phenomena in their social world. Clearly, it is precisely these historical experiences that vary between age cohorts. Furthermore, regarding the possible clinical implications of this research, it would be particularly pertinent to discover whether people destined for different services by virtue of their age held different views about psychology, as this



would impact upon decisions concerning the most beneficial way for each service to interface with its pool of potential clients. For these reasons, then, this study aimed to access two different age cohorts of participants: 25-35 year olds (potential users of adult, child and family services) and 65-75 year olds (potential users of older adult services).

In addition to potential differences between age cohorts, there is considerable evidence that there are consistent and replicable sex differences in help-seeking for psychological issues (Deane & Todd, 1996; Wills & DePaulo, 1991), with females of different ages and nationalities consistently demonstrating more openness to seeking professional help (Fischer & Turner, 1970; Leong & Zachar, 1999) and less treatment fearfulness (Kushner & Sher, 1991), regardless of sexual orientation (Modcrin & Wyers, 1990). This factor also has considerable clinical implications. Thus, in order to explore possible sex differences in social representations, equal numbers of men and women in the two age categories were recruited.

As the present study aimed to focus on possible age and sex differences in social representations, the decision was made to constrain other demographic factors which might influence social representations. The study therefore recruited participants who are all tabloid readers. The rationale for this is that tabloid readers make up the majority of the general public, and therefore the majority of the pool of potential clients for any NHS psychology service. Since within a social representation perspective there is an emphasis on the mass media as instigators and carriers of social representations, the decision to sample from a population who all tend to access similar media examples was also theoretically driven (Bauer & Gaskell, 1999).

Social representations theory, with its emphasis on socio-cultural context, also suggests that ethnic identity is likely to shape social representations. A decision was therefore made to ensure that all participants were from a similar ethnic background. People were thus only recruited if they described their ethnicity as white British. This category was chosen because it is the most common in the UK.

Finally, in order to get a sense of the social representations circulating amongst lay people in general, it seemed reasonable to exclude people who had had direct personal contact with psychologists. Social representations theory proposes that people who have had no direct experience of a phenomenon will nevertheless hold socio-culturally determined ideas with which to anchor the phenomenon (Bauer & Gaskell, 1999). Existing literature suggests that this is the case for phenomena associated with psychological services (Pilgrim, Rogers, Clarke & Clark, 1997).

The aim of the current study, then, was to elucidate the social representations of psychology and the psychologist held by members of the British public. This was done using a primarily qualitative analysis of semi-structured interviews. This enabled the gathering of data rich enough to be of use in drawing out the symbolic, cultural and emotional underpinnings of the themes in relation to the topic. In an exploratory, qualitative study of this nature it was not appropriate to make a priori predictions. Instead, the study aimed to access social representations of psychology and the psychologist in men and women in the two age groups as a means of addressing the following research questions :-

- *What meanings do people construct and assign to the concept 'psychology'?*
- *What meanings do people construct and assign to the concept 'psychologist'?*

## **METHOD**

### **OVERVIEW**

Thirty two members of the public participated in a semi-structured interview which focused on their views about the nature of psychology, its practitioners and its clients. The interview data were analysed using a form of content analysis (Berelson, 1952; Holsti, 1969; Krippendorf, 1980). Social representations theory (Moscovici, 1984) was chosen to provide a framework guiding the analysis, because it encompasses a consideration of both the individual's beliefs and emotional responses, and the socio-cultural context in which they have arisen.

This chapter details how the study was carried out in terms of the recruitment of participants, the demographics of the sample, the interview, and the data analysis. Ethical considerations and the researcher's personal perspective are also made explicit.

### **ETHICAL CONSIDERATIONS**

Ethical approval for the study was sought from the Joint University College London / University College London Hospitals Committees on the Ethics of Human Research. A copy of the letter granting ethical approval is presented in Appendix I.

Participants were given an information sheet on the study, a copy of which is presented in Appendix II. They were therefore made aware that the interview would be audiotaped if they consented to participate. Informed consent was obtained in writing. A copy of the consent form is presented in Appendix III.

Confidentiality was maintained by ensuring participants names did not appear on the audiotape or its container, or the subsequent transcript. Instead, each participant was assigned an identifying number and no record was kept of which signed consent form corresponded to which identifying number. Also, the signed consent forms were kept separately from the tapes and transcripts.

All participants, including those in the pilot studies, were paid five pounds for their time. This payment was made in cash prior to commencing the interview.

If participants had any questions during the course of the interview, it was explained to them that there would be time at the end for questions to be answered. Interviews lasted, on average, about half an hour. At the end of the interview, participants were thanked for their help and any outstanding questions were answered. The participants were also given a contact number for the researcher, in case any other queries about the study occurred to them later.

## **RECRUITMENT OF PARTICIPANTS**

This study aimed to recruit members of the general public. In order to access the general public, a number of community centres, social clubs and working mens clubs in north, south, east and west London were approached by the researcher, either by phone or in person. The only considerations in choosing which centres to approach were that they had a London postcode and that they were near to convenient public transport.

In each case, the researcher talked to the person in charge of the centre and introduced herself as “a researcher working for the NHS and the University of London”. She then explained that she was looking for members of the public between the ages of

25-35 and 65-75 to talk to for about half an hour each concerning their knowledge about certain aspects of the health service, for which they would each receive five pounds in cash. She then asked if the centre catered for the two age groups required and, if so, whether the person in charge would mind if she approached people at the centre and invited them to participate. The researcher was permitted to have access to ten of the thirteen centres which were approached.

Different centres were visited at different times, depending on the clientele. This was done not only to maximise the chances of suitable people being there, but also to ensure that visits were made at times when it was most likely that people would have time to sit and be interviewed for half an hour. For example, most of the female participants were recruited by targeting community centres at times when parent and toddler groups or pensioners lunch clubs were in progress; most of the older male participants were recruited by targeting working mens clubs during the afternoons; most of the younger male participants were recruited by targeting working mens clubs and social clubs in the evenings.

When potential participants were approached, the researcher introduced herself by her first name and gave the same speech she did when approaching the centre managers. In only five cases did people decline from participating at this stage. The reasons given were either because they did not want to or because they did not have time (e.g. because they had to go and pick up their child from school). However, in the majority of cases the person was willing to consider participating. They were then asked to read the participant information sheet about the study (see Appendix II). It was explained to them that if they signed the consent form and agreed to participate, the researcher would first have to

establish if they fitted the categories required (i.e. the inclusion criteria), and that if the criteria excluded them, then the interview would not be conducted and they would not be eligible for the money. All but one person chose to continue by signing the consent form (see Appendix III). If they met the criteria for inclusion, they were paid before the interview.

## **PARTICIPANTS**

The inclusion criteria were selected by making theoretically and empirically guided decisions as to where group differences in social representations might be hypothesised to occur. This was necessary in order to ensure a meaningful segmentation of the overall social milieu termed ‘the public’ (Bauer & Gaskell, 1999).

In terms of theoretically guided decisions, social representations theory suggests that factors such as ethnic identity, age, and exposure to similar written mass media are likely to shape social representations. This is because these factors are seen as indicative of socio-cultural and historical context. Furthermore, in order to get a sense of the social representations circulating amongst lay people in general, it seemed reasonable to exclude people who had had direct personal contact with psychologists.

In addition, in terms of empirically guided sampling, existing empirical work, which has been cited in the ‘Introduction’ chapter, suggests that views about psychology may vary with age (e.g. Furnham & Wardley, 1990; Hopson & Cunningham, 1995).

In the light of these considerations, the inclusion criteria used in this study were as follows:-

- White British given as self-reported ethnicity, with English as first language

- Aged either 25-35 (i.e. an age group eligible as potential users of adult, child and family psychological services) or 65-75 years old (i.e. an age group eligible as potential users of older adults psychological services)
- Described self as literate
- Reader of only tabloid newspapers (e.g. 'The Sun'; 'The Mirror'; 'The Daily Mail'; 'The Daily Express'; 'The Daily Star'; 'News Of The World'; 'The Sunday People'), not broadsheet newspapers (e.g. 'The Times'; 'The Daily Telegraph'; 'The Guardian'; 'The Observer'; 'The Independent')
- Never had any direct personal contact with a psychologist

Fifteen of the people approached who agreed to participate did not fit one or more of these criteria. In all, 32 participants were recruited: 16 in the 25-35 year old group (8 women; 8 men); 16 in the 65-75 year old group (8 women; 8 men). Equal numbers of men and women were recruited in each group so that sex differences, as well as age differences, could be explored. The decision to do this was guided by existing empirical work, cited in the 'Introduction' chapter, which suggests that men and women may have different views about psychology (e.g. Deane & Todd, 1996; Leong & Zachar, 1999).

The sample therefore consisted of 4 groups with 8 participants in each group. In an attempt to sample a spread of potential participants, half of the participants were recruited from centres in parts of London south of the Thames, and the other half from centres in parts of London north of the Thames. This meant that within each of the 4 groups, half of the sample, i.e. 4 people, were recruited from south of the river and half from north of the river.

The mean ages of the participants, in years, were as follows: older men – 70; older women – 69; younger men – 28; younger women - 30.

The participants reported reading a number of different tabloids, with some people mentioning more than one. These are listed here in order of popularity, with the numbers in brackets referring to the number of participants who reported reading that paper: ‘The Sun’ (21); ‘The Mirror’ (13); ‘The Daily Mail’ (7); ‘The Daily Star’ (2); ‘The News of The World’ (2); ‘The Daily Express’ (1); ‘The Sunday People’ (1).

The participants were also asked to outline their educational background, their occupational history and whether any relatives or close friends had ever had any direct personal contact with a psychologist. These additional demographic details were obtained in order to get a better ‘feel’ for the sample.

Twenty six of the participants had left school with few qualifications; five had gone on to some kind of further training, such as secretarial college, teaching certification, City & Guilds gardening examinations; one had a degree.

Twenty four of the participants worked, or were retired from, unskilled or semi-skilled jobs, such as building work, lorry driver, shop work, child care. The other eight participants worked, or were retired from, skilled or professional jobs, such as teacher, social worker, personal assistant. All sixteen women were also homemakers.

Four participants reported that family or close friends had been to see a psychologist (1 sister; 1 husband; 1 wife; 1 close friend’s children). Three others were unsure if the person seen had been a psychologist, but reported that psychiatric help had been sought (2 brothers; 1 ex-girlfriend).



## **THE INTERVIEW**

Once informed consent had been obtained, the researcher sat with the participant in a quiet corner or room at the centre and conducted the interview, with the audiotape machine placed nearby unobtrusively. Interviews lasted, on average, about half an hour.

A semi-structured interview format was chosen, as this ensured that the same broad issues were covered in each interview. The questions were constructed with consideration as to how best to access participants' underlying meaning systems for the concepts 'psychology' and 'psychologist'. Examples of strategies employed were the use of open-ended questions, the encouraging of participants to express their own views, the avoidance of "Why ...?" questions, the following up of ideas using participants' own phraseology, and the asking of participants to imagine how they would feel if they themselves were in a particular situation (Hollway & Jefferson, 1997; Leong & Zachar, 1999).

The first draft of the interview questions was piloted on two of the researcher's personal acquaintances who fitted the inclusion criteria. One was a 29 year old man, and the other was a 74 year old woman. The interview questions were modified according to the feedback from these participants. These modified interview questions were then piloted on four members of the public who fitted the inclusion criteria.

The first and second drafts of the interview questions had used the terms 'clinical psychology/psychologist'. The pilot interviews suggested that the inclusion of the term 'clinical' had caused considerable confusion, such that much of the time during the second set of pilot interviews was spent with participants expressing concern that they did not know what this meant. As the extent of their confusion seemed to make them feel

uncomfortable within the interview situation, a decision was made to remove the term 'clinical' from the interview questions, so that participants were asked more generally about 'psychology' and 'psychologists'. Not only did this seem ethically justified, in terms of ensuring participants well-being (Elliott et al, 1999; King, 1996), but it also opened up the study to include the possibility that participants might mention aspects of psychology not directly related to the clinical field.

The final draft of the interview questions which were used in the study is presented in Appendix IV. In summary, the questions explored participants responses to the word 'psychologist', to meeting a psychologist, to finding out that someone they knew had been to a psychologist, and to being told to see a psychologist themselves. They were also asked what psychologists do and whether there are other people who have a similar function.

Where necessary, probes were used to encourage participants to expand on their responses. The types of probes used most often were :-

- encouraging participants to 'have a guess' if they expressed uncertainty, for example, if they said that the word 'psychologist' triggered no particular thoughts for them.
- an explicit inquiry about their feelings on a particular issue, for example, asking about the feelings they might have if they heard that someone they knew had been to see a psychologist
- an explicit inquiry about what meaning they would assign to certain eventualities, for example, asking them what it would mean to them if someone said they should see a psychologist

- a following up of responses using participants' own language with the intonation of a question, to encourage the participant to elaborate, for example, when a participant said *"I'd think 'Oh God!', because its like you're going mental, you're losing the plot"*, the probe was *"Going mental? [pause] Losing the plot?"*

The focus throughout all the interviews was on maintaining an interested and non-judgmental stance by giving verbal and non-verbal feedback cues in order to encourage participants to 'tell their story' (King, 1996). A 'socio-emotional' style of interviewing was used (Diesling, 1981). This involved keeping interactions as similar as possible to everyday social conversation, and yet with a careful avoidance of the use of leading questions or comments. Every attempt was made to minimise assumptions. Thus where it was hypothesised that a particular idea was being held, every effort was made to explore the issue with the participant for purposes of clarification and to test the hypothesis, but without leading their responses.

### **RESEARCHER'S PERSONAL PERSPECTIVE**

Qualitative researchers have argued that attempting to remain 'neutral' when engaging with research participants is, at best, futile, and is likely to result in unnatural interactions (King, 1996; Yardley, 2000). It has been argued that it is thus good practice for researchers to be explicit in reporting their personal perspective, so that the reader can evaluate what impact this might have had on the research process, and therefore on the data obtained (Banyard & Hunt, 2000; Elliott et al, 1999; Smith, 1996).

It therefore seems appropriate to report that this study was conducted by a white British middle class woman in her early thirties. Although the study was specifically

approached using a social representations theory framework, in broader terms, the researcher's general approach was to adopt a social constructionist view of respecting individual perspectives.

In a deliberate effort to reduce the inevitable power imbalance between researcher and participant (King, 1996; Yardley, 2000), the researcher dressed and spoke casually for all interactions with participants. The aim of this was to try to seem more like a student and less like a professional, in the hope that this would help participants to feel more comfortable, and facilitate them in talking more freely about their views.

## **ANALYSIS**

The method of analysis employed in this study was a form of content analysis (Berelson, 1952; Holsti, 1969; Krippendorff, 1980). Content analysis aims to use unstructured qualitative data in order to make valid inferences about hypothesised underlying constructs. The central aim of this study was to use a form of content analysis to classify the words in participants' narratives into thematic categories. The content of these categories was presumed to reflect aspects of participants' social representations. Although the emphasis was on the manifest content of communications (Berelson, 1952), it is argued that this can provide an inroad into richer, more hidden meanings (D.Rose, 1996).

Various forms of content analysis have been developed which, due to epistemological variations, differ in the extent to which they incorporate quantification (Henwood, 1996). The present study used a more traditional approach which included some quantification (Holsti, 1969). The approach focused on creating a systematic coding

frame of the thematic categories which comprised the manifest content of participants' accounts. Social representations theory proposes that social representations are reflected in ideas which are shared across a social group (Joffe, 1999). The number of participants who used each thematic category was therefore recorded to give an indication of the extent of consensus.

The first stage of the analysis was to transcribe the interviews from the audiotapes. This was done verbatim, with the only notation being the use of three dots to indicate a pause of any length, i.e. "...". As the focus was on manifest content, no attempt was made to represent subtleties, such as particular intonations. A sample transcript is presented in Appendix V.

The next stage involved selecting the five transcripts which seemed, at first sight, to be the most complex. Each of these was then read through systematically with the purpose of identifying and listing emergent themes. The focus was on themes which related to the meaning systems the participants seemed to be using in order to make sense of the concepts 'psychology' and 'psychologist'. The emergent themes across all of these five transcripts were then compared, and themes with similar meaning were merged together.

Another five transcripts were then chosen and thematically categorised in the same way. The emergent themes from these five were then compared with the master list from the first five transcripts. Similar ideas were merged into already existing categories and new categories were created to encompass new ideas. This process was repeated until all thirty two transcripts had been codified.

The final list was studied and discussed with the research supervisors, to ensure that all possible categories had been identified and all similar categories had been merged. The result was a large number of separate semantic themes. These were then collected hierarchically into meaningful clusters. After a final round of merging of categories within the clusters, this hierarchical arrangement constituted the final coding frame for the data. It is presented in Appendix VI.

The coding frame was then operationalised and entered onto the computer using a specialist software package for qualitative research called QSR NUD\*IST (Gahan & Hannibal, 1998). This software stores all the quotes relevant to each theme within the appropriate category or categories of the coding frame.

The coding frame consisted of five main clusters, called 'parent nodes' in QSR NUD\*IST terminology. Each of these focused on a different aspect of the emerging representations, although inevitably these aspects were interdependent :-

- the discipline of psychology
- the nature of the problems psychology addresses
- the processes involved in psychology
- the psychologist
- the client

All thirty two transcripts were then re-read and re-coded with respect to each parent node in turn, using QSR NUD\*IST. For example, all thirty two transcripts were re-read with the categories of 'the discipline of psychology' in mind, and re-coded onto the computer accordingly. This was then repeated for each of the other parent nodes. This

repetition was necessary in order to be thorough, because it was not possible to retain all the categories for each parent node in mind simultaneously.

Once all the transcripts had been coded in this way, QSR NUD\*IST was used to generate frequency data as to how often each semantic category had been used across the sample as a whole. Because the aim was to identify consensus across participants, where it emerged that a category had been used only once or twice, it was either discarded or merged with another minor category to yield a category which was either broader in nature, or termed 'miscellaneous'. In some cases, however, an infrequently coded category was deliberately retained because the very scarcity of it was particularly salient (D.Rose, 1996). These decisions regarding infrequently coded categories were made by discussion with the research supervisors.

Overall, this method enabled the coding and quantification of the manifest content of the transcripts. This focus on manifest content was a means of erring on the side of conservatism and caution. This was necessary because only one researcher was analysing the data and it was therefore important to try to minimise the impact of that one person's subjective interpretations.

One way of checking the objectivity of the coding was to have a second person use the coding frame on a subset of the data. Hence, once the final decisions had been made regarding infrequently coded categories, four of the transcripts were coded by a second rater, who was an assistant psychologist. The second rater was initially trained by the researcher on the use of the coding frame. The researcher then went through one transcript with her, so that she could see the coding process in action. Four transcripts

(12.5% of the data), one from each of the demographic groups, were then chosen at random for her to code by herself.

There was good broad agreement on the main categories, with disagreements mostly resolvable through discussion. However, where there were a number of subtly different sub-categories, agreement was more problematic. There were two particular 'trouble spots' where this was the case. In each of these cases, the second rater and the researcher had agreed on the overall category, but disagreed on the subtler sub-classification. For example, under the parent node 'the client', one category was 'expressions of stigma'. Under this category there were seven sub-classifications for the way in which the stigma was expressed. The disagreements that were hardest or impossible to resolve occurred, not in deciding whether stigma was being expressed at all or not, but between these seven sub-categories. A similar problem arose within the parent node 'the psychologist' concerning the category 'invokes feelings of threat', which had nine sub-categories related to what the participant seemed to feel was the cause of this feeling of threat.

There are two conclusions from these observations. Firstly, if some of the fine-grained sub-classifications had been merged together for clarity, agreement would have been considerably higher. Secondly, these observations suggest that the coding frame was generally fairly robust, because even where there were disagreements these were quite subtle. It is therefore argued that these would not have had major implications for the validity of conclusions drawn from the results.



# **RESULTS**

## **OVERVIEW**

The results are presented in two main sections, which follow from the two principal research questions. Inevitably these two sections are overlapping and interdependent, but this division allows for conceptual clarity. The two sections have been further divided into sub-sections. These are derived from the coding frame, which is presented in Appendix VI. The subsections are listed here in order to give the reader a framework with which to approach this chapter :-

### **1. WHAT IS PSYCHOLOGY?**

- 1.1 What disciplines is psychology anchored to?
- 1.2 What is the subject matter of psychology?
- 1.3 What kinds of issues does psychology address?
- 1.4 What causes the issues which psychology addresses?
- 1.5 What attributions are made about the locus of psychological problems?
- 1.6 What processes does psychology involve?
- 1.7 How does psychology work?

### **2. WHAT IS THE PSYCHOLOGIST?**

- 2.1 What professional groups is the psychologist anchored to?
- 2.2 What non-professional groups is the psychologist anchored to?

- 2.3 What is the psychologist's role in society?
- 2.4 Are psychologists useful?
- 2.5 What kind of person is the psychologist?
- 2.6 What kinds of emotional responses does the psychologist invoke?
- 2.7 What are the psychologist's clients like?

Within each sub-section the most consensual ideas are presented first, as it is these that are taken to be the most illustrative of the representations which are held across the sample. These representations emerging across minds, rather than purely within minds, are the focus for a social representational perspective, as they are deemed to be part of the “canopy ... woven by people's concerted talk” (Wagner, Duveen, Farr, Jovchelovitch, Lorenzi-Cioldi, Markova & Rose, 1999).

After a consideration of the consensual aspects of the representations, each sub-section explores other interesting and salient ideas that emerged, including group differences where relevant. The aim of this study was to explore possible group differences within a qualitative framework, rather than to test for differences. A decision was therefore made to define ‘salient group differences’ as instances in which an idea was mentioned by at least twice as many of one group compared to the other, provided that the numbers were not too small. For example, it was decided that, if a category consisted of only 2 men and 1 woman, this would not be reported because the numbers are too small for it to be classified here as a salient sex difference. Where possible group differences are reported, the number of participants concerned is clearly presented.

Each sub-section then concludes with a short summary of the main ideas that emerged. As far as possible, interpretations of the meaning of the results are not addressed in this chapter. Instead, these are explored in the 'Discussion' chapter.

The results reported concentrate on the meaning participants assigned to the concepts 'psychology' and 'psychologist'. Information that emerged concerning more practical issues has been omitted, such as participants' beliefs about where their ideas had come from or knowledge about referral routes.

Where percentages are reported, these always refer to the percentage of the total sample of 32 participants. However, in many cases participants made more than one type of response in a given category, so total percentages often add up to more than 100%.

Because coding focuses on the manifest content of participants' accounts, quotes are used throughout to illustrate, but these do not have any special linguistic notation. The only notation used is three dots, i.e. "...". This is used in this chapter to indicate deliberate omission of material, which has been done in order to demonstrate a particular point succinctly.

Where quotes are presented, these are followed by a code which identifies the demographic group and the individual participant's number. For the purposes of this chapter, the relevant part of this code is the first two letters, as these indicate the demographic group: the first letter denotes the age group of the participant (Y indicates 'younger group'; O indicates 'older group'), and the second letter denotes their sex (M indicates 'man'; W indicates 'woman'). The remainder of the code is not relevant here, as it is simply the individual's participant number. For example YMS-3 indicates a 25-35

year old man, YWN-1 indicates a 25-35 year old woman, OMN-4 indicates a 65-75 year old man, and OWS-2 indicates a 65-75 year old woman.

## **SECTION 1: WHAT IS PSYCHOLOGY?**

### **1.1 What disciplines is psychology anchored to?**

Almost all (94%) of the sample mentioned other disciplines in giving an account of what psychology is. The following disciplines emerged as anchors :

- Medicine – 29 (91%) participants
- Science – 3 (10%) participants
- Complementary medicine – 2 (6%) participants
- Miscellaneous idiosyncratic anchors – 4 (13%) participants

Twenty nine (91%) of the 30 participants who referred to at least one body of knowledge made a clear statement implying that they viewed psychology as a medical discipline, and located it within a traditional Westernised medical model :

*“Oh yeah, yeah! Anything to do with the medical profession and all that, innit!”*  
(OMS-2)

*“ ... seeing as I don't know exactly what part of medicine they belong to, I would probably want to know a little bit more about it, but if it was good for me then you need to go.”* (OWS-2)

*"[The clients are] ... sick and they probably needed help that a normal doctor or someone like that can't give them. They've had to go and see someone a bit higher up." (YMS-4)*

However, despite the prevalence of anchoring psychology to medicine, several participants seemed to consider psychological help to be qualitatively different to medical help :

*" ... with psychology or psychiatry or anything like that, its not something that is going to manifest itself externally ... because ... I guess that ... for a lot of people its just something that happens gradually, so there's ... there's no tests they can do that say "Oh yeah, you need to see this person. You need to get all this treatment. You need to do this. Because we've done this scan, or we've done this X-ray." Its kind of just ... oh yeah, everything is kind of inside your head and ... I guess its kind of the ... the problem is that ... I can think about my arm, about whether its broken or not broken, but I can't think about whether my mind is broken or not broken, because my mind is used to think about my mind, so if my mind's broken, then that affects whether, y'know, I can ascertain whether I need some help with it, so its not straight out sort of yes I need some help or no I don't need some help." (YMN-1)*

*"I mean if you sprain your wrist or anything and they say 'Oh you want to go to the doctor' or 'You want to go and have an X-ray', well that's all right. That's*

*acceptable. But to say you need to see a psychologist ... I'd think 'What have I done? What makes them think I should go and see one of them?'" (OWN-2)*

The 2 (6%) participants who made no reference to a particular body of knowledge did mention psychiatrists in connection with psychology, but without specifically stating that they viewed them as medical professionals, hence they were not recorded as anchoring psychology to medicine.

Eight participants out of the 29 who anchored psychology to Western medicine also anchored it to other bodies of knowledge. Out of this segment of the sample, three (10%), all of whom were from the younger age group, also linked psychology to science :

*"Science. It sounds sciency ... or someone like a doctor." (YWS-3)*

Two (6%) of the older men in this segment also linked psychology with particular forms of complementary medicine in addition to medicine (reflexology and hypnosis).

Four idiosyncratic anchors also emerged. It is worth noting that one of these was a link between psychology and personal growth/self-help :

*"I'm quite interested in this kind of stuff myself, cos I follow a 12 step programme ... And I read a lot of spiritual books and stuff as well ... Like 'The Road Less Travelled' ... I read kind of a lot of those kind of books" (YWN-4)*

*Summary*:- The most striking observation is that the vast majority of the participants anchored psychology within medicine, whilst other bodies of knowledge were only relatively rarely incorporated into the representations. Medicine and science were overlapping anchors for a few younger participants, whilst medicine and complementary medicine overlapped for a couple of the older participants.

## **1.2 What is the subject matter of psychology?**

Twenty five (78%) participants produced ideas concerning what psychologists study and what psychology is about, i.e. the subject matter of the discipline. Psychology was viewed as the study of :

- the mind – 23 (72%) participants
- thinking and/or thought processes – 10 (31%) participants
- behaviour – 6 (19%) participants
- the brain – 5 (16%) participants
- feelings – 5 (16%) participants
- personality – 1 (3%) participants

The most common representation, fairly evenly spread across the groups, was that psychology was the study of the mind. This theme was expressed by 23 of the 25 participants who discussed the subject matter of psychology :

*“Obviously with ‘psych’ and all that sort of stuff its got to do with the mind ...”*

*(YMN-1)*

The general sense seemed to be of psychologists looking into the problems in people's minds :

*"[Clients have] got something wrong with their mind ... [Psychologists] try to read the minds of them." (OMS-1)*

*" ... there's a problem there and again in the mind ... [Psychologists] help the mind and find out what's going on inside." (YWS-4)*

Fifteen of the 23 participants who viewed psychology as the study of mind also expressed ideas related to other possible categories: 'thinking' (8 participants), 'brain' (5 participants), 'feelings' (4 participants), 'behaviour' (4 participants) and 'personality' (1 participant).

The only salient group difference was that out of the 10 participants who mentioned 'thinking', only 3 were women.

Summary: The majority of participants viewed psychology as the study of the mind. All of those who viewed it as study of the brain or of personality had also mentioned it as being the study of the mind.

### **1.3 What issues does psychology address?**

All the participants made at least one reference to the types of issues they believed psychologists would address. The mention of types of 'generic' problem, for example



‘mental illness’ and ‘distress’, and ‘specific’ problem, for example ‘depression’ and ‘dementia’, were common throughout the sample. Twenty four (75%) participants mentioned examples of both types.

‘Generic’ problems were mentioned by 27 (84%) participants. These were :

- ‘Mental issues’, including specific references to clients as being mentally ill or psychologists as dealing with mental issues, such as mental illness, mental problems, mental instability, mental health or mental disorders – 18 (56%) participants :

*“Well they’re probably frightened about the fact that they’re not quite well in the head ...Maybe they’ve got a mental illness or something. Would that be why you see a psychologist? I don’t know.” (YMN-2)*

*[Context: participant explaining how she would feel if she had to see a psychologist]*

*“I think you think that you’re going mental, which you’re not because you can still talk and everything, but I think you think you’ve got a mental problem and y’know that’s the end of the line ... that’s how I would feel ...” (OWN-1)*

- ‘Distress’, including distress, disturbance, upset and emotional difficulties – 14 (44%) participants :

*“Well a lot of people get distressed over different things ... and I think these people that get distressed, they go to see somebody. They need to see someone to help them*

*get over it. I think this is what psychology is. Its to help people cope with distressful times ...” (OMN-1)*

- ‘Coping difficulties’, including references to struggling to cope with, deal with or handle life – 12 (38%) participants :

*[Context: participant is explaining what it is about being told to see a psychologist that would make her angry] “Thinking that I’m some sort of nutter! That I’m mad! I’m not capable of doing daily chores normally ... I just can’t handle it. They’re saying I can’t handle these. Its just the thought that goes through your mind that I can’t handle everyday life.” (YWS-2)*

In addition, a wide range of ‘specific’ problems were mentioned by 29 (91%) participants, the three most common being :

- ‘Depressive problems’, including depression, bereavement and what participants referred to as ‘nervous breakdown’ – 18 (56%) participants :

*[Context: participant is describing what she associates with the word ‘psychologist’:-] “If you have a nervous breakdown ... [Interviewer: What did you mean by a ‘nervous breakdown’?] People can’t cope any more or they’re sort of unhappy in their lives sort of thing ... They’ve had a lot of sadness, a lot of trouble in their life and they can’t sort of handle it properly.” (OWS-3)*

- ‘Antisocial behaviour’, including criminality, violence, temper outbursts and general references to antisocial behaviour which did not specify its nature – 9 (28%) participants :

*[Context: participant is imagining how he would react if he met a psychologist:-] “Dunno what sort of psycho patients do you have? What sort of incidents and bits of violence? Have they ever lashed out at you or something? Still associate psychology with sort of mentally ill people, people that lash out, that are violent and do all sicko things ... going on the tube and stabbing people up ... Just hitting people for no reason. Unprovocated [sic] violence and stuff like that.” (YMN-4)*

- ‘Self harm’, including suicide, attempted suicide and other forms of self harm – 8 (25%) participants :

*“ ... I must say that I do believe that there are very good reasons - at times - for people to have this kind of support. When they have problems that they obviously cannot deal with themselves ... The person who contemplates suicide, for instance, has obviously got to the stage when he can't deal with his own problems ... And somebody else needs to help him.” (OMS-3)*

There were a number of other ‘specific’ problems that were mentioned by less than a quarter of the sample :

- 'Anxiety problems', including worry, stress, pressure and phobias – 6 (19%) participants
- 'Dementia', including references to dementia, Alzheimer's disease and senility – 6 (19%) participants
- 'Relationship issues', including family and marital/partner problems – 6 (19%) participants
- 'Abuse of children', including abuse by adults, physical or sexual, and abuse by other children, e.g. bullying – 4 (13%) participants
- 'Addiction', including drugs and alcohol – 4 (13%) participants
- 'Behavioural problems in children', including Attention Deficit Hyperactivity Disorder (ADHD) – 4 (13%) participants
- 'Learning difficulties', including references to learning disabilities, and children with dyslexia, dyspraxia and special needs – 4 (13%) participants
- 'Psychotic', including references to schizophrenia, paranoia and so-called 'split personality' – 3 (10%) participants
- 'Trauma', including references to psychologists dealing with people who had been through trauma – 3 (10%) participants
- 'Stroke', including references to psychologists dealing with stroke victims – 1 (3%) participant

In terms of group differences, as regards the three categories of 'generic' labels for problems, these were used relatively uniformly across the sample, with the exception that the younger men used only the 'mental issues' category.

In terms of 'specific' problems, men tended to mention 'antisocial behaviour' more than women (6 men; 3 women), and only women mentioned 'nervous breakdown' and children's problems (0 men; 4 women). Older participants more commonly mentioned 'antisocial behaviour' (6 older; 3 younger), and 'dementia' and 'anxiety problems' (5 older; 1 younger for each), and less commonly mentioned 'depression' (4 older; 9 younger).

*Summary:* The majority of participants seemed to carry representations which included both generic and specific problem labels (75%). 'Mental issues' and 'depressive problems' were the only categories mentioned by over half the sample. 'Coping difficulties' and 'distress' were mentioned by well over a third of the participants, and 'antisocial behaviour' and 'self harm' by around a quarter.

#### **1.4 What causes the issues which psychology addresses?**

In thinking about what causes the issues psychology addresses, twenty (63%) participants spontaneously used at least one type of aetiological formulation, with 8 (25%) using more than one. The ideas that arose were :

- 'Distal experiences', i.e. distal, often childhood, experiences as causal agents – 8 (25%) participants :

*“ ... I feel that everything ...that we are really really moulded by our childhood ... when I'm in certain situations I just react and I know its nothing to do with what's*

*going on in that situation. Its coming from somewhere else ... and then sometimes I can unravel where its coming from ... and to me that's all to do with psychology ... I'm just really aware at the moment about childhood coming out in your adulthood." (YWN-4)*

- 'Proximal experiences', i.e. recent experiences as causal agents – 7 (22%) participants:

*[Context: participant is describing how she would know she needed to see a psychologist:-] " ... there could be a breakdown of relationship, or everyday life, stress from work, and you end up having a breakdown and its ... you know ... you can't get a grip on things any more. Everyday life, it becomes hard for you." (YWS-2)*

- 'Medical illness', i.e. explicit references to a medical condition as cause of the problems – 5 (16%) participants :

*[Context: participant is explaining what it would mean to him if he heard that someone he knew had seen a psychologist:-] "That they were sick and they probably needed help that a normal doctor or someone like that can't give them ... Its like going to a normal doctor. I suppose if you're ill, you have to go and see someone ..." (YMS-4)*

- 'Brain dysfunction', i.e. brain dysfunction as causal agent – 3 (10%) participants :

*"I mean to say, let's say for argument's sake I suddenly forgot what I'm doing, forget things, and I don't know what I'm doing from one day to the next, then, all right, if a doctor suggested, I'd have to go [to see a psychologist], because there's something wrong with my brain. Its not reacting to what I want it to do ... Is it a part of your brain that is not acting properly, or reacting properly?... Because when you start to go mental it means a part of your brain is closing down, as far as I know it does, anyway." (OMN-2)*

- 'Systemic or social causes', i.e. dysfunction of a system, or events/changes in society as causal – 3 (10%) participants :

*" ... it wasn't something that I'd heard of years ago, so its something that's probably come with these times we're living in now. There's a lot more pressure on people. They didn't seem to care in the old days ... I think there's a lot of pressure on the youngsters and that." (OWS-2)*

- 'Thinking errors', i.e. errors or irrationalities in thinking as causal agent – 3 (10%) participants :

*" ... the ones that are ... whose thoughts are wrong ... yeah I think they should see the psychologist." (OMN-1)*

- ‘Congenital causes’, i.e. idea that people are born with problems – 1 (3%) participants:

*“ ... I suppose some people can be born with phobias about things ... ” (OWS-1)*

Almost two thirds of the sample, spread evenly across the groups, expressed some ideas regarding the aetiology of the problems addressed by psychologists, but only a quarter of the sample expressed ideas relating to more than one such model. This suggests that most people had some type of aetiological formulation within their representation of the problems addressed by psychologists. However, there did not appear to be majority consensus as to any specific aetiological model or models. Nevertheless, it seemed that the most common general idea was that problems were caused by the impact of events, either from the recent or distant past. When these two categories – ‘distal experiences’ and ‘proximal experiences’ - were combined to form a broader category concerned with the aetiological role of individual experiences, some interesting group differences emerged. This combined category tended to include more women than men (4 men; 8 women), and more younger than older participants (4 older; 8 younger).

Around a quarter of the sample mentioned some kind of physical cause, i.e. ‘medical illness’, ‘brain dysfunction’, ‘congenital cause’. There appeared to be an age difference as regards the two categories of physical causes, in that ‘brain dysfunction’ seemed to be a causal mechanism put forward by older participants, rather than younger (3 older; 0 younger), with the converse pattern for ‘medical illness’ (1 older; 4 younger).



Only women mentioned 'systemic or social causes' and 'congenital causes' as aetiological models.

*Summary:* Almost two thirds of the sample expressed theories about the aetiology of the problems which psychologists address. The most commonly cited view was that problems were due to the impact of individual experiences. This view was more common in women than in men, and in younger than older participants.

Around a quarter of the sample mentioned physical causes, with older participants more commonly implicating brain dysfunction. In contrast, younger participants more commonly used medical illness as an aetiological model.

Only women mentioned systemic/social and congenital causes.

### **1.5 What attributions are made about the locus of psychological problems?**

Three quarters of the sample made some attribution as to the locus of the problems which psychologists address. The majority of the participants (59%) used some form of internal attribution for the locus of the problems. Nevertheless, there was still a substantial percentage (41%) who did attribute the locus of problems externally. A quarter of the sample used both internal and external forms of attribution.

Internal attributions located the problems as being either in the individual's mind, or their behaviour or their brain :

- 'Intrapsychic deficit', i.e. a deficit or deficiency in the mind of the individual as the locus of the problem – 15 (47%) participants :

*[Interviewer: When I say the word 'psychologist', tell me what's going through your mind?] " ...It means people who are mentally disturbed or something like that and ... there's something wrong with you and your health's not all that good, but there's something wrong in your mind ... you need watching and treatment."*  
(OMS-4)

- 'Behaviour of the individual', i.e. references to the problem residing in the behaviour of the individual – 8 (25%) participants :

*[Context: participant is explaining why people have suggested in the past that he should see a psychologist:-] "Well I think its cos of the way I used to be. I'm changing now, settling down, growing up ...Before I just didn't give a shit what I done or who I done it to or where I done it or whatever ... And no-one's said it recently, so they must have seen a change as well."* (YMS-3)

- 'Neurological deficit', i.e. a physical deficit or deficiency in the brain of the individual as the locus of the problem – 4 (13%) participants :

*[Context: participant is describing her view of clients:-] "They are mixed up ... Don't know which way to turn. I'm not going to say its not a disease of the brain, cos it possibly could be ... if a certain part of the brain in a certain way is touched ..."* (OWS-2)

External attributions located the problem in the impact of external events or relational events :

- 'Stress model', i.e. references to the problem residing in the impact of the external on the individual – 12 (38%) participants :

*“ ... its all just social pressure and life pressure and it just makes you react the way you are for a while and once you've sort of eased the pressure level, you can get on with normal life again.” (YWN-3)*

- 'Interpersonal relationships', i.e. references to the problem residing in the relationship between individuals – 3 (10%) participants :

*[Context: participant is reflecting on the idea of having someone say she should go to a psychologist:-] “I mean quite honestly, I've said that myself to my grandchildren. You know, they've been arguing and on and I've said 'You need to see a blooming psychologist, the way you're going on' ... They're always fighting and yet they won't go anywhere without each other.” (OWN-2)*

In terms of sex differences, the sole use of internal attributions was more common amongst the men (9 men; 2 women), whereas the sole use of external attributions was more common amongst the women as the men (1 man; 4 women). The use of both internal and external attributions was also more common amongst the women (2 men; 6

women). In particular, the women were more apparent than the men in the ‘stress model’ category (3 men; 9 women) and were the only sex in the ‘interpersonal relationships’ category (0 men; 3 women).

Also, older participants more than younger ones tended to mention ‘intrapsychic deficit’ (11 older; 4 younger) and ‘neurological deficit’ (3 older; 1 younger).

*Summary:* Three quarters of the participants expressed ideas about where the problems psychologists address are located. The locus of problems was most commonly attributed internally (59%), with the most common idea being to view problems as due to an intrapsychic deficit within the mind of the individual (47%). Nevertheless a considerable proportion of the sample used external attributions (41%).

The most salient sex difference was the observation that the men tended to attribute problems internally, whereas the women tended to attribute problems externally, most commonly using a ‘stress model’, or to mention both internal and external attributions.

## **1.6 What processes does psychology involve?**

Twenty eight (88%) participants spontaneously expressed ideas concerning how psychologists went about their work, in terms of what processes they believed to be salient when psychologists were working with clients.

The view that talking was a part of the process was the most consensual idea mentioned by almost two thirds of the participants (63%), spread evenly across the groups :

*“ ... there are things in life you can't deal with on your own and you need ... you maybe need someone else to talk to and discuss things with, someone that can give you a different view about a problem ... they're there to help you talk through your problems ... approach them from different angles and things like that ... ” (YWN-3)*

The second most common idea, mentioned by 13 (41%) participants, was that questioning is part of the process of psychology. This was more prevalent amongst the older participants (10 older; 3 younger) :

*“They probably ask you lots of questions ... I think you often see these things in the movies where you lay on the couch and they ask you questions and those sorts of things ... ” (OWS-2)*

The idea that the psychologist delves into, digs into, looks into or reads the mind or thoughts as a part of the process of psychology was mentioned by 12 (38%) participants :

*“[Psychologists are] people who will help ... or hopefully help, anyway. You hear some stories of some ... off-the wall psychologists, shall I call them, because ... who search, dig deep and try to root into people's minds and try to find outlets*

*that will enable them to identify with something that they've never let themselves previously ... some of them dig deep and delve and try and find things ...”*

*(YMS-1)*

A quarter of the sample made reference to listening as a part of the process of psychology :

*“[Psychologists are] there to listen ... its like the third ear so to speak ... it's a listening ear, isn't it? Somebody ... who doesn't really know you, but is still willing to listen and take onboard your problems ... so its like a third ear is a listening ear ... its cos its like somebody whose going to listen to you and not say anything back that you're not going to want to hear, until you're ready to hear it.” (YWN-1)*

Five (16%) participants discussed the engendering of trust and/or the encouragement of opening up as a part of the process of psychology :

*“They talk to you and try to get you to pour out things you probably wouldn't say to anybody else ... I think they could probably get you to talk, you know, if you wouldn't talk to a very good friend or family member. You'd probably open up to them ...” (OWS-1)*

The least commonly mentioned process was that psychologists administer tests.

This idea was only expressed by 2 (6%) participants, both older women :

*“ ... they put you through a test ... Give you something to do, maybe give you some writing to do ... ” (OWN-4)*

Summary: The most commonly expressed view, shared by almost two thirds of the sample, was that talking was an inherent part of the process of psychology. The second most common idea was that questioning is part of the process, but this was mentioned predominantly by the older participants. Over a third of the sample mentioned psychologists as delving into or reading the mind, whilst a quarter mentioned listening skills. Less than a fifth of the participants spoke of the engendering of trust or the encouragement of opening up as part of the process, whilst only two mentioned test administration.

### **1.7 How does psychology work?**

Twenty five (78%) participants, evenly spread across the groups, expressed ideas on the mechanism of action of psychology, their beliefs as to how it works and what they see as the agent of the therapeutic effect.

The majority of ideas that emerged could be conceptualised in two categories: ‘expert’ models, i.e. ideas which placed the psychologist in an expert role, as the active agent, with the client as the more passive recipient of the psychologist’s expertise, and ‘collaborative’ models, i.e. ideas which viewed the therapeutic effect of psychology as

being the result of a collaborative process between psychologist and client. Although expert models were used the most (69%), collaborative models were also fairly common (41%).

The most common type of idea in the 'expert' model category was a general reference which placed the psychologist in an active expert role, doing something for or to the client, but which did not specifically state what this may be (38%) :

*"If you know people are troubled and they have to go and see a psychologist, they're looking for someone to straighten them out ..."* (OMN-3)

Around a fifth of the participants (22%) expressed the idea that the therapeutic effect is due to the psychologist giving the client advice to follow :

*" ... if someone's cut up in their own mind they reckon they want someone to speak to and someone to give them advice ... I mean if someone can give them advice or listen, whether they're giving the same answer or different answers, I don't know."* (OWS-2)

The same number of participants (22%) felt the therapeutic effect resulted from the psychologist solving the problem for the client :

*"They try to get in your mind, I suppose. Sort out your problems ... everyday problems or whatever ... Having a discussion like we are for about 2 or 3 hours."*



*Trying to sort out the pros and cons, sort of thing, so that they came up with an answer.” [Interviewer: “And who would come up with the answer?”] “The bloke interviewing you, the professional ...” (OMS-2)*

Five other types of expert model emerged, each of which was mentioned by only 2 or 3 participants. One such model was that the therapeutic effect is due to the psychologist ordering the client’s thoughts correctly or correcting the mind (10%) :

*“They analyse people’s thoughts and perhaps arrange them in a correct manner ...” (YMN-2)*

There were 3 participants (10%) who viewed the therapeutic effect as being due to the psychologist administering medication :

*“I mean they do put you in a room, don’t they, and they’re watching you and watching you and they more or less find out what treatment they think ... what medicine to calm anyone down, it all depends what the strength of it is, what type of illness they’ve got ... They’ve got so much more ... better medication [nowadays]. They’re so up, aren’t they now, on their medicines.” (OWN-3)*

Three participants (10%) saw the therapeutic effect as being due to the psychologist calming the client or teaching them how to calm themselves through relaxation :

*“They tell the person to relax and things like this. This is what I think it is. I think once they’ve assessed the person, they’ll know what sort of thing they’re going to do ... tell them to relax and calm them and make sure that their state of mind can be not too irrational. This is what I think. I’m not sure ... I think psychology is ... there is one side of psychology that does the relaxation classes, or something like this ...I think relaxation classes. I think this helps calm the mind. I think this is what it is.” (OMN-1)*

Two participants (6%) expressed the belief that the therapeutic effect is due to the psychologist being a practitioner of some type of complementary medicine :

*“I think there are some that use sort of hypnotic, hypnotist don’t they. Put you under to read your mind and ask you questions. I mean to say I’ve seen some of this on television, you know, in these what they call educational programmes, where they put a person under, ask them a lot of questions, and then they say “Well you’re going farther back”, but as I say, I don’t know.” (OMN-2)*

Finally in the expert models category, 2 participants (6%) viewed the therapeutic effect as being due to some kind of simple or magical solution that the psychologist possesses and applies :

*“There’s nothing clever about it, basically ... Its if you read a few text books, you read a few books, you know about the Oedipus Complex and all this sort of stuff. There must be about five of those things that you can take as generalities that you can then apply to standard people types.” (YMN-1)*

Moving now to consider the ‘collaborative’ models category, the most common idea here, expressed by just under a fifth of the sample, was that the therapeutic effect is due to the psychologist asking the right questions, thereby facilitating insight and self-cure in the client (19%) :

*“Well I think a good one would, would ... umm ... ask the individual questions so the individual was coming up with the answers, not the psychologist ... and by asking the questions to the individual you are helping them, the individual ... umm ... come up with their truth, come up with their reasons, rather than placing these thoughts onto the individual.” (YMS-1)*

Five (16%) participants explicitly expressed the importance of the client as an active participant for any therapeutic effect to occur :

*“I suppose if its voluntary, the person would start opening out and saying “I’ve got this problem, that problem”. I’m not sure whether ... It would have to be to voluntary, I would think, or ... I’m not sure ... But if its not voluntary, then I suppose you just sit there and go “There’s nothing wrong with me”, but if it is*

*voluntary, then they'd say "I've got this problem. My wife does this.", or "My girlfriend does this. My Mum done that and my Dad done that".*" (YMN-4)

There were 4 (13%) participants who viewed the therapeutic effect as being due to the psychologist functioning as an objective listener or sounding board for the client :

*"I mean I hear lots of things here from people who use me as a sounding board. They speak to me of problems they have so in a very, very small way I suppose it's a kind of psychology that you're using to help them."* (OWS-2)

Three participants (10%) expressed the idea that the therapeutic effect is due to the client becoming able to shift their views to alternative perspectives as a result of discussions with the psychologist :

*[Context: participant is sharing her reflections on her sister's experience of seeing a psychologist:-] " ... like you've got a view on a subject. I don't think you can make someone change their mind on it. Its very hard, very difficult, but you can sort of give them another alternative way of thinking, which they did with her...gave her an alternative way of thinking...that things weren't that bad after all..."* (OWN-1)

Two participants (6%) mentioned the view that the therapeutic effect comes from having the opportunity to talk with a qualified professional :

*“You mean when a patient goes to them? I think they just talk to them and talk them through their problem. I don’t know, but I think you go there and they talk to you and they listen ... talk you through all different issues. I’m probably way off! As I say, I don’t really know!” (OWS-3)*

Finally, there were two idiosyncratic collaborative models: 1 participant viewed the therapeutic effect as being due to the catharsis of emotion, and 1 participant mentioned the importance of a match between psychologist and client in order for there to be a therapeutic effect, i.e. that they should ‘click’ with each other.

Around a third of the sample used both ‘expert’ and ‘collaborative’ models, whilst another third used just ‘expert models’. Only 2 participants just used ‘collaborative’ models. This suggests that the importance of collaboration was a reasonably widespread idea, but was generally secondary to the view of psychologists as active experts.

Some salient group differences emerged in the use of ‘expert’ versus ‘collaborative’ models. The sole use of ‘expert’ models was more common amongst the older participants (9 older; 3 younger). The converse pattern emerged in the use of ‘collaborative’ models, in that this was more common amongst the younger participants (4 older; 8 younger).

In terms of salient sex differences concerning usage of specific types of each model, men more often than women used the ‘expert’ models of psychologist as advice-giver (6 men; 1 woman), psychologist as responsible for correcting thinking (3 men; 0

women), psychologist as calming and teaching relaxation (3 men; 0 women), and psychologist as practicing complementary medicine (2 men; 0 women).

On the other hand, only women expressed the 'collaborative' models of psychologist as sounding board (0 men; 4 women), psychologist as facilitating development of alternative perspectives (0 men; 3 women), and talking with the psychologist as inherently therapeutic (0 men; 2 women).

Regarding salient age differences, older participants more often than younger ones used the 'expert' models of psychologist in a general active expert role (10 older; 2 younger), psychologist as advice-giver (5 older; 2 younger), psychologist as administering medication (3 older; 0 younger), and psychologist as practicing complementary medicine (2 older, 0 younger). Conversely, younger participants more often than older ones used the 'collaborative' model of psychologist as asking the right questions to facilitate insight and self- cure (2 older; 4 younger).

*Summary:* Over two thirds of the sample, spread across the groups, viewed the therapeutic effect of psychology as the result of some type of expert intervention done for or to the client, who is therefore seen as a relatively passive recipient. On the other hand, well over a third of the sample thought the therapeutic effect resulted from a collaboration between the psychologist and the client. There was considerable overlap in the use of these contrasting models, as a third of the sample adhered to both viewpoints.

However, the idea that psychology works solely by virtue of the psychologist's active expertise were more common amongst the older participants, whilst the additional use of collaborative models was more common amongst the younger ones.

## **SECTION 2: WHAT IS THE PSYCHOLOGIST?**

### **2.1 What professions is the psychologist anchored to?**

Having already discussed the disciplines to which psychology was anchored in section 1.1, the current section focuses on the particular professional groups which were used as anchor figures. Thirty (94%) participants anchored the psychologist to at least one type of professional person. The key professional anchors to emerge were :

- Psychiatrist – 24 (75%) participants
- Type of doctor – 18 (56%) participants
- Counsellor – 9 (28%) participants

Most of the participants (75%) used the psychiatrist as the professional anchor for the psychologist, and this was observed evenly across the groups. Out of the 24 who used it as an anchor, 14 described psychologists as the same as psychiatrists :

*“I think to me they’re all the same – psychiatrists, psychologists. As I say, I don’t really know ... I’ve always assumed that psychiatrists, psychologists and that, they’re all the same. They all do the same sort of thing.” (OMN-2)*

However, the other 10 participants out of the 24 saw psychologists and psychiatrists as different in some way. Some focused on illness as a differentiating factor:

*“Well, a psychiatrist, to me, as opposed to a psychologist, is someone who’s trying to help someone who’s mentally sick. A psychologist will analyse you. To*

*my mind, that's what I know, he will analyse you, but a psychiatrist is trying to analyse a sick person. I always assimilate psychiatry with sickness. As opposed to psychology.” (OMN-3)*

*“ ... because mental illness, as I say, is an illness – schizophrenia and I assume the other mental illnesses – whereas a lot of people with depression what have you, its all just social pressure and life pressure and it just makes you react the way you are for a while and once you've sort of eased the pressure level, you can get on with normal life again ... psychiatrists are more to do with actual mental illness, rather than just someone who's having a difficult time and can't really cope too well at the moment.” (YWN-3)*

Other participants emphasised the level of distress :

*“I think you'd have to be really ill ... really bad ... to see a psychiatrist ... it'd be more important, you know, more urgent to go to, probably. You'd probably have more problems ...” (OWS-1)*

Some participants viewed psychologists as more research-oriented :

*“I think they're both of the same profession, but I think psychologists go into the background of it, research the background more, where psychiatrists talk to the people more. You know, psychologists are there to back the psychiatrists up in certain issues, certain matters, but the psychiatrist is there initially for you to go*



*and see, like, that way. They're more up front and more with the people, more with everyday life, and I think the psychologists are those that are there as back-up and there as standby because they research all the background to the human brain and to how you work and to everyday things that you do.” (YWS-2)*

Finally, some participants found it difficult to explain their views on the difference :

*“Oh no, there's, there's, there's obviously there must be a difference, otherwise they'd be called 'psychologist' or 'psychiatrist' ... but I don't have ... uh ... a technical term of what one does and what the other one doesn't, as such. But ... they're from the same school ... or the same ... certainly yeah from the same school ... sorry to be so vague ... ” (YMS-1)*

The second most commonly used professional anchor, mentioned by over half the sample (56%), was a type of doctor, often with the connotation of high status :

*“[If someone had seen a psychologist it would mean that] ... they were sick and they probably needed help that a normal doctor or someone like that can't give them. They've had to go and see someone a bit higher up ... [Psychologists] realise you need specialist help and they just help you like any specialism ... obviously with psychologists they have to be a bit more something like clued up than what a normal GP does. I would have thought so.” (YMS-4)*

*“[A psychologist is] ... a big doctor who can look into people's minds.” (YMN-3)*

Overall, all the 30 (94%) participants who mentioned a professional anchor used either ‘psychiatrist’ or ‘doctor’. There was considerable overlap between the categories, in that 13 (41%) participants referred to both of these categories in their narratives.

In addition to ‘psychiatrist’ and/or ‘doctor’, 12 participants (37%) also used other health professionals as anchors, i.e. ‘counsellor’, ‘therapist’, ‘shrink’ or ‘psychoanalyst’, whilst 3 (10%) participants used other caring professionals as anchors, i.e. ‘social worker’ and/or ‘careworker’.

The most common of these additional categories was ‘counsellor’, used by 9 (28%) participants. Only 2 of these were men, both from the younger age group. These 2 men seemed to view the psychologist and the counsellor as virtually interchangeable :

*“I ain't an expert but I guess there's ... in my opinion there's probably three or four different people ... counsellors ... that probably do a similar job, possibly.”*  
*(YMN-2)*

In contrast, the 7 women had more of a tendency to represent psychologists as different to counsellors, often in terms of having greater expertise :

*“Well I suppose they [counsellors] are not psychologists. I've heard people who've been referred to counsellors to go and have a chat about problems, you know? ...I don't know if they refer on from ... if you can be referred from a*

*counsellor to a psychologist. I don't really know but I think it might be probably a good idea at the beginning, but I wouldn't think they'd be as qualified as a psychologist." (OWS-1)*

A number of other professional anchors emerged, each of which was mentioned by only a few participants: 'therapist' and 'teacher' (3 participants each); 'shrink', 'psychoanalyst', 'social worker', 'care worker', 'educational psychologist', 'people with titles, such as lawyers and politicians', and 'people who give physical help' (2 participants each). Only younger participants mentioned 'therapist', only women mentioned 'psychoanalyst', and only older men mentioned 'shrink'.

There were also a number of one-off idiosyncratic anchors: hypnotist; witch doctor; archeologist; general health service workers; careers advisor; Citizens Advice Bureau; Robbie Coltrane's 'Cracker' (a character in a TV drama who is a forensic psychologist); 'Dear Deirdre' (a newspaper agony aunt).

Summary: The vast majority of the sample anchored the psychologist to the psychiatrist and/or to a type of doctor. Almost half the participants viewed the psychologist as the same as the psychiatrist, whilst around a quarter saw them as different in terms of psychologists being less involved with severe distress or with illness, or being more research-oriented.

Just over a quarter of the participants also anchored the psychologist to the counsellor, but these were predominantly women, plus a couple of younger men.

Whereas these men tended to see psychologists and counsellors as similar, the women generally viewed psychologists as more expert.

## **2.2 What non-professional people is the psychologist anchored to?**

Thirteen (41%) participants, evenly spread across the groups, used non-professional people as anchor figures. The most common non-professional anchor was 'friend' (28%), followed by 'family' (22%), and 'type of advisor' (19%). Out of the 9 participants who used 'friend' as an anchor, two types of response emerged across the age groups, with an interesting sex difference. Three participants, all men, seemed to view 'friend' and 'psychologist' as virtually interchangeable :

*“The person who contemplates suicide, for instance, has obviously got to the stage when he can't deal with his own problems ... And somebody else needs to help him. If that's a psychologist or a doctor or a very good friend or someone with experience of the kind of problem that they're facing, that's it, you know! I don't say necessarily there has to be a psychologist.” (OMS-3)*

In contrast, 6 participants, only one male, seemed to feel that psychologists generally did have a specific role to play beyond that of a friend :

*“I think they could probably get you to talk, you know, if you wouldn't talk to a very good friend or a family member. You'd probably open up to them and ... they might want to talk to you and talk you through it.” (OWS-1)*

In a similar vein, out of the 7 participants who used 'family' as an anchor, the 4 men viewed 'family' and 'psychologist' as virtually interchangeable :

*"I mean to say, there was talk of her going to see a psychologist because she still harps on it, even after all these years, but we talk to her and that ... we calm the situation. She doesn't have to go to a psychologist cos the family deals with it. We keep it in the family." (OMN-2)*

On the other hand, the 3 women saw psychologists as having a different role to family members :

*" ... probably in their profession as psychologist they could explain a lot more. A lot of people say ... I don't know if its true or not ... but if you go and speak with somebody not part of your family or friends, you can speak a lot more clearly than you can with a person that's not biased, so it could help in that way."*  
(YWN-3)

The 'type of advisor' category (19%) included accounts which anchored the psychologist to a role model or mentor, to someone who has had similar experiences, and to someone who has had extensive life experience :

*“ ... somebody else needs to help [if someone has a problem]. If that's a psychologist or ... someone with experience of the kind of problem that they're facing, that's it, you know! I don't say there necessarily has to be a psychologist ... A person with wide experience of people with problems is probably going to be as good a psychologist as one who went through college and started off at the very roots aiming to be a psychologist ... a young person at work who looks up and respects an older person at work, you know, and has that kind of what, in today's parlance, is a strong role model ... would be able to exercise the same kind of effect upon a person as a psychologist.” (OMS-3)*

**Summary:** Less than half the sample (41%) used types of informal helper as anchors, i.e. non-professionals. It is striking that, out of those who used ‘friend’ or ‘family’ as anchors, the men seemed to view psychologists as similar in function to such informal social networks, whilst the women more readily expressed ideas of the psychologist as having a role beyond that of family and friends.

### **2.3 What is the psychologist's role in society?**

Thirteen (41%) participants made references to the kinds of roles they saw psychologists as having within society. The most common idea, expressed by a quarter of the sample, was that psychologists played a role in social control related to the Mental Health Act, such as involuntary detainment and institutionalisation :

*“... its only when you get into the big ... the big kind of major psychological problems that perhaps you need someone that’s really trained in it ... when you get to sectioning people and all that sort of stuff ... someone who is a danger to themselves or a danger to society ... or just somebody that is just so ... not really out of control ... but so ... not out of control but dangerous, I suppose ... that they can’t be ... that they can’t be controlled by their family, and its causing a lot of problems throughout everyone, and its better for them to be put somewhere where they don’t want to be cos its gonna be helpful to them.” (YMN-1)*

*“ ... Cos I think a lot of people are frightened and they think “Ooh!” ... Not everyone, but I think ... some people they think “Ooh they’re going to have me put away!” (OWS-1)*

Some other ideas also emerged, such as psychologists being viewed as status symbols for the wealthy (3 participants), and as general authority figures in the social hierarchy (2 participants).

Summary: Less than half of the sample mentioned their views on the role of psychologist’s in society. The most common view, expressed by a quarter of the participants, associated psychologists with social control measures.

## **2.4 Are psychologists useful?**

Eighteen (56%) participants made comments regarding the utility value of psychologists. Fourteen (44%) participants viewed psychologists as useful/helpful, 3 (10%) viewed them as not useful or potentially harmful, and 7 (22%) expressed ambivalence as to their usefulness. Five (16%) of the participants who commented on usefulness made more than one type of response.

The women who expressed opinions regarding the utility value of psychologists generally seemed quite positive. Ten women saw psychologists as useful, compared to 2 who were ambivalent or saw them as not useful. All the older women who expressed a view saw them as useful (5 out of 5), as did most of the younger women (5 out of 6) :

*“I don't think we could do without them, let's put it that way. Well because there are lots of people that need them, or need their help or need something. If they didn't have the psychologist they'd have to have somebody else.” (OWN-2)*

In contrast, the men who expressed opinions regarding utility generally seemed more negative, in that only 4 of them saw psychologists as useful, compared to 8 who were ambivalent or saw them as not useful. The younger men viewed them as useful or were ambivalent. However, most of the older men viewed them as not useful, as illustrated in the first quote below, or were ambivalent, as in the second quote :

*“ ... I mean to say, if a person has got any worries, they may say all right go and speak to somebody about it and discuss it, but I don't think they could help them*



*all that much. I wouldn't say so, anyway ... And if he starts to delve back and brings that up, it ain't going to do much good, is it? Well I wouldn't think so anyway."* (SMN-2)

*"I am sceptical .. not so. I think that there are cases when it is advantageous, when it is a help, but I think that too many people are ... there's only one word to use ... gutless, and rush to it, rush to counselling and help from somebody else when they should really get down to sorting out their own problems."* (OMS-3)

**Summary:** More than half the sample commented on the utility value of psychologists. Almost half the participants viewed psychologists as useful, whilst just under a quarter expressed some doubts. There seemed to be a tendency for the older women to be the most common group in expressing positive views about utility, followed by the younger women, with the younger men less sure and the older men being the most sceptical.

## **2.5 What kind of person is the psychologist?**

The most common idea, expressed across the groups by almost two thirds of the sample (63%) was that psychologists were academically inclined, in terms of being either highly educated and/or intelligent :

*" ... they're trained to be who they are and they're specialists. Its probably a lot of hard work ... Must be a lot of work ... they're top, clever people ... I suppose they have to go through a lot of strenuous training. Like I know normal doctors ...*

*but obviously psychologists they have to be a bit more something like clued up than what a normal GP does. I would have thought so. They must be clever people.” (YMS-4)*

Thirteen (41%) participants commented on the kinds of personality characteristics they associated with the psychologist. A number of descriptors emerged, which were grouped into two categories :

- ‘positive characteristics’, such as kind, caring, good-hearted, unpressurising; objective; impartial; not self-disclosing; down-to-earth; non-judgmental; strong and coping – 9 (28%) participants :

*“ ... and that person doesn’t know you so they’re not going to judge you, and they let you talk about anything or almost anything ... They wouldn’t force you into talking about anything if you didn’t want to, I don’t think.” (YWN-1)*

*“I’ve never thought of psychologists as not being nice people ... I think they must be nice people to want to help people. I don’t see it as a negative. I perhaps see psychologists as positive.” (OWS-4)*

- ‘negative characteristics’, i.e. expressions of psychologists as being weird or abnormal – 6 (19%) participants :

*“Well I should imagine they think “This must be a queer woman or a queer bloke” like, you know what I mean, in this sort of job and things like that ...”*  
(OMS-4)

*“ ... people think [psychologists are] sick! ... I mean I couldn't be a psychologist because I couldn't go and listen to everybody else's problems ... day in and day out, and I think a lot of people think that way as well...Its like “You must be mad! Why are you doing a job like that, listening to everybody else's problems?” ... a lot of people would think ... “Why a psychologist?... is there something wrong with you? ... do you like listening to people's problems” ... or something along those kind of lines ... its like ... thriving on somebody else's problems. I know they don't, but ...uh... I mean say in a crowd with people they think “Well they obviously enjoy they're job. They like people's troubles” I suppose... y'know, misfortunes...cos they get paid for it...they get paid for listening to peoples' misfortunes, so people think it's a bit sick...”* (YWN-1)

In terms of sex differences, it is interesting that women more commonly mentioned 'positive characteristics' (3 men; 6 women), whereas men more commonly mentioned 'negative characteristics' (4 men; 2 women).

Another intriguing observation is that some accounts expressed the idea of the psychologist as having both 'positive' and 'negative' traits :

*“ ... a listening person, a caring person, someone that when you was at school or something was always like “Hi. What are you doing? How are you?” and wants to know what you’re doing and how you are, I suppose. Someone that cares”*  
(YMN-4)

And then several minutes later in the same interview :

*“...I think the patients and the psychologists themselves might be a little bit weird, if they do it. I’m not sure ... I would imagine that most people think that it’s a bit weird to be a psychologist. Not weird, but a little strange to be a psychologist. Its not like a doctor or somebody. An actual psychologist who sits down and speaks ... and sorts out people’s problems each day would be a little bit ... a little bit deep and ... not your normal job. Not your normal office job.”*  
(YMN-4)

Summary: Almost two thirds of the sample saw psychologists as clever and/or highly educated. Less than half the sample commented on other personality characteristics. These were categorised here as either positive or negative. Two thirds of those who viewed psychologists as demonstrating positive characteristics were women, whilst two thirds of those who viewed psychologists as weird or abnormal were men.

## **2.6 What kinds of emotional responses does the psychologist invoke?**

Thirty (94%) participants discussed the kinds of emotional response that might be invoked in people by psychologists. The most consensual response, mentioned by 28 (88%) participants was of feeling threatened in some way :

*“Where a lot of people are afraid of them ... whereas me, I’m not afraid of a psychologist or of having to go and see one either.” (YWN-1)*

*“I’d begin to worry about myself, thinking whatever’s wrong? And I’d think what are they seeing in me that I can’t see in myself ... I’d think I’m getting older ... maybe I’m going into Alzheimer’s or something like that ... I think you think that you’re going mental, which you’re not because you can still talk and everything, but I think you think you’ve got a mental problem and, y’know, that’s the end of the line ...” (OWN-1)*

*“They’d probably be a bit suspect as to what their conversation would be, like if they were asking sort of half personal questions, whether they were trying to get in a bit too deep, and trying to know a bit too much about what the other person’s life is like.” (YMN-4)*

*“Well I think the person that’s got to see the psychologist might get a reaction that why should I see him, or why should I see a psychologist when I don’t need to? I would think the reaction would be a hostile reaction if they think that ... a lot*

*of people when they hear the word 'psychologist' or 'psychiatrist' it brings out this "But I'm not mad! Why should I go and see these people?" And when they eventually do go to see them, they're very tensed up, so tensed up that they become hostile and they will not co-operate." (OMN-1)*

Within the 'threat' category itself, there were a number of different kinds of conscious explanation given for the sense of threat, with many participants mentioning more than one such possible explanation. Almost a quarter of the sample (22%) made a general reference to fear, with no explanation given, such as the first example above. Other occurrences were more specific, the two most common being :

- fear of being thought to be abnormal, mad, weird (see second example given above) – 17 (53%) participants. This fear was more common amongst the older participants (11 older; 6 younger)
- fear of being analysed, the outcome and the motive for it (see third example given above) – 15 (47%) participants. This fear was more common amongst the younger participants (4 older; 11 younger)

There were also a number of other specific types of response within the 'threat' category which arose less frequently :

- hostile response, i.e. denial of need to see a psychologist or contempt towards psychology (see fourth example given above) – 7 (22%) participants

- expressions of feeling hurt or upset when faced with the thought of seeing a psychologist – 6 (19%) participants
- fear of appearing foolish or ignorant – 5 (16%) participants
- fear of being locked up – 4 (13%) participants
- fear of the subject matter, i.e. finding the subject matter of the psychologist's job uncomfortable, and therefore fear of having to discuss it – 2 (6%) participants
- fear of having an emotional outburst – 1 (3%) participant

There were some salient group differences between these minor categories of 'threat'. Men more commonly expressed a hostile response than women did (5 men; 2 women), whereas women more commonly than men expressed feelings of threat in terms of feeling hurt or upset at the thought of seeing a psychologist (2 men; 4 women).

The second most common emotional response discussed by the sample was intrigue or interest in what the psychologist would say (28%) :

*"Oh I'd be interested. I'd chat with them all night. I'd be interested to see how ... what they do ... Oh I'd be so interested in seeing how they go about, what training they done, all things like that." (YMS-4)*

*"I'd want to know who, what, why, I would! Cos its something I'm interested in ... " (OWS-4)*

Such interest was expressed by more women than men (3 men; 6 women), and more younger participants than older ones (3 older; 6 younger).

Finally, some other emotional responses were mentioned less frequently, such as relief at seeing a psychologist (13%), awe at the status of the psychologist (10%) and envy at the job (3%). Concurring with the pattern in the 'intrigue' category, the majority of participants who expressed these ideas were women.

*Summary:* By far the most common emotional response to the psychologist invoked throughout the sample was one of feeling threatened, which was mentioned by almost all of the participants. Older participants tended more than the younger ones to express this as a fear of being thought abnormal, whereas younger participants had a greater tendency than the older ones to report fear of being analysed. The men more commonly than the women expressed a feeling of threat as a hostile response, whilst the women more commonly than the men expressed a feeling of threat in the form of feeling hurt or upset.

Just over a quarter of the sample expressed the idea that people might be interested or intrigued to see or meet a psychologist. However, this idea was more common amongst the women than the men, and the younger participants rather than the older ones. Ideas of relief, awe and envy were expressed only by women.

## **2.7 What are the psychologist's clients like?**

Most of the participants (91%) spontaneously produced accounts of psychologists' clients which were oriented around the issue of stigma. Because this issue was so prevalent across the sample, this section categorises the data in terms of the types



of stigma-oriented discourse that emerged. Most participants used more than one of these types.

Stigma-oriented ideas appeared to be present at different levels of conscious awareness. Only 5 (16%) participants, 4 of whom were women, discussed stigma at the most conscious level, by directly and explicitly acknowledging it as an issue :

*“There’s a stigma to having been to see a psychologist ... But I certainly wouldn’t think that! But I’m sure there are people who do, who think “Ooh its such a shame to bring on the family, if I’ve been to see a psychologist” ... and I’m sure its not! ... I think they feel ashamed to think they’ve got a problem that they haven’t been able to deal with themselves ... ” (OWS-1)*

In contrast, the most common type of stigma-oriented discourse seemed to be at a less conscious level, as it involved the implicit expression of stigma by the direct use of derogatory terminology, such as ‘mad’, ‘weird’, ‘loonie’, ‘nutter’ etc. This type of discourse was apparent in more than two thirds of the participants’ accounts (69%) :

*“When you say ‘psychologist’, probably that are not ... that are more mentally sick than anything else. People who don’t ... from day to day who are like mentally ill and need help constantly ... I mean when you say ‘psychologist’, probably people think you’re mad or something like that ... is the first reaction ... I’m losing it ... That I’m going a bit mad ... [Its] the word ‘psychiatrist’ [sic], I think ... It really is associated with people ... well you think its people who are*

*mad, people like that. So when someone said you had to go and see a psychiatrist [sic], you think that you're losing your marbles, or something like that.” (YMS-4)*

Other more subtle expressions also emerged, suggesting that, in these instances, the impact of stigma-oriented ideas was even further from conscious awareness. These subtle expressions were divided into three categories, the most common of which (50%) was the expression of negative emotion, such as anger or fear, at the thought of seeing a psychologist :

*“ ... if it was your doctor ... said “I think you need to see a psychologist”... and then initially you'd probably think a lot about “Ah, the bastard” and stuff like that, because you would think, wouldn't you, like about “Nah ... he doesn't know what he's talking about!”, and then after you'd slept with it for a couple of nights, it would be “Oh ... oh maybe I do”, and then you probably wouldn't, in the end ... because psychology and all that is to do with the mind ... if somebody questions that, its kind of questioning your whole line of thinking, your whole reason for being who you are ... ” (YMN-1)*

The second most common type of subtle expression of stigma (41%) involved the tacit implication that being a client means the person is deviant from acceptable norms in some way :

*“I mean if you sprain your wrist or anything and they say “Oh you want to go to the doctor” or “You want to go and have an X-ray”, well that’s all right. That’s acceptable. But to say you need to see a psychologist ... you know I’d think “What have I done? What makes them think I should go and see one of them?” ... If they didn’t have the psychologist they’d have to have somebody else ... [Before there were psychologists]... Perhaps they were just shoved into mental homes and that was it.” (OWN-2)*

The least common type of subtle expression, used by only 2 (6%) participants, was the adopting of the stance that it is acceptable for others to see a psychologist, but not for the participant themselves to do so :

*“I mean to say if I’ve got problems, I get out of them myself. I sort it out myself. I certainly wouldn’t ask to go and see a psychologist, or a shrink as I call them ... [If someone goes to see a psychologist it means ] they can’t cope on their own. They’ve got to go and see somebody like that ... for them to help them, I presume. Say where as I can cope, even with all my illnesses I’ve had, I’ve still coped on my own. I’ve had the wife there behind me and my sisters, and that’s it. But it’s entirely up to them what they do. I wouldn’t say anything to them to upset them, if they told me they’d been to see one. I’d just say ‘OK. Fair enough. If that’s what you want, OK, fine.’” (OMN-2)*

The pervasive impact of stigmatising ideas thus appeared to be influential at different levels of conscious awareness. However, some participants also seemed, at times, to be aligning themselves against this dominant discourse and thereby challenging it. In some cases (19%), this appeared to be at a conscious level, in that the participants explicitly expressed the view that stigma was inappropriate :

*“Mad person! Asylum! Yes, I think that’s what that is – the general opinion is “Oh my God! Am I really losing it? Am I cracking up? No, I can’t be. Am I going to be put away in a straitjacket and locked in an asylum?” I think that’s the general opinion that most people would think that a psychologist is, when they’re not, I don’t think. They’re just as human as anybody else, bar that they’ve studied this, and they’re there to help.” (YWS-2)*

More commonly (31%), this alignment against the dominant stigmatising discourse appeared to be at a less conscious level, as the view of stigma as inappropriate was expressed by the subtle use of language. This was more apparent amongst women than men (2 men; 8 women) :

*“I wouldn’t be shocked in any way, if someone had seen a psychologist ... Oh it wouldn’t bother me [if someone said I should see a psychologist]! ... Where a lot of people are afraid of them ... whereas me, I’m not afraid of a psychologist or of having to go and see one either...” (YWN-1)*

Some participants moved even further towards challenging the dominant discourse by expressing positive and/or supportive views regarding clients. However, although such views were expressed by over a third of the sample (34%), all of the people concerned had also used stigma-oriented ideas elsewhere in their accounts. Positive and/or supportive views regarding clients were expressed by more women than men (2 men; 9 women). The most common of these ideas was that it is a good or healthy or positive move to become a client of a psychologist (28%), such as in the first quote below, whilst a smaller minority (13%) expressed compassion regarding clients' distress, as can be seen in the second quote below :

*“Well to me [if I found out someone was seeing a psychologist] it would say about them that they were willing ... to look at themselves more deeply, sort of, and to accept help ... and , that, y’know, there’s nothing wrong with that. I don’t think there’s anything wrong with accepting help from someone ... yeah I would think it was a good idea ... like a healthy thing to do, I would think ... Seeing a psychologist I think would be all right, like I totally agree with that ... ” (YWN-4)*

*“I’d just think to myself that, well, I’m sorry, like, if she’s not ... you know, like mentally a bit disturbed, but personally it wouldn’t affect me talking to the person or anything like that.” (OMS-4)*

Finally, in addition to all the value judgments inherent in both the stigmatising and the positive responses to clients, half the sample also expressed neutrality or indifference to the idea of people being clients :

*“I just wouldn’t take no notice of them really [if they suggested I should go to a psychologist] ... It wouldn’t really bother me, to be honest with you.” (YMS-2)*

*“I wouldn’t have a particular reaction one way or the other because there must have been reasons for them going to see a psychologist. I might ask why ...” (OWS-4)*

This stance of neutrality was more common amongst the men (11 men; 5 women), and emerged, in all but 2 cases, in the accounts of participants who had also used stigma-oriented ideas. It may, therefore, at least in some cases, have reflected a decision or an attempt made by the participant to position themselves as opposing a stigmatising discourse, for instance due to a social desirability bias. This possibility is illustrated by this exchange between participant and interviewer, in which the participant almost appears to be trying to convince herself that she would not behave differently towards someone if she found out they were going to a psychologist :

*“ ... it wouldn’t make any difference to me, if they’d had to [go to a psychologist]. It’s not catching. Even if it was, you’d take a chance. It doesn’t matter.”*  
*[Interviewer: “When you say “it’s not catching”, what’s the ‘it’?”] “Well, like*

*people saying to keep away from those children cos they've got chicken pox ... We're all a bit wary, I suppose of some things. You're taken aback perhaps. I don't know. Probably don't mean anything. I'm not really sure." [Interviewer: "And what would it say about the person? What would it mean?"] "Wouldn't make them a different person, surely! Its just like someone telling you they've gone to the doctor's or to the hospital or something like that." [Interviewer: "And how would you feel in that situation? What would be going through your mind?"] "I don't think I'd feel any different. I don't think so. Why should you? That's what I mean! Why should you? It doesn't make them a different person, surely. Its just that they've got something going on or they need something. It doesn't change things." (OWS-2)*

**Summary:** The majority of the participants oriented their discourse about clients around the issue of stigma, which was expressed in a number of different ways. Stigma-oriented ideas were most often expressed implicitly and subtly, with only a few participants directly acknowledging the issue of stigma in their spontaneous accounts. This suggests that stigma operates at different levels of conscious awareness.

A substantial minority of participants also, at times, challenged this dominant stigmatising discourse by explicitly or implicitly presenting it as inappropriate, by expressing positive ideas about clients, or by expressing indifference.

Women were more common than men in directly acknowledging the issue of stigma, in presenting it as inappropriate, and in expressing positive ideas about clients. Men were more common than women in expressing neutrality or indifference towards

clients, although this may have reflected a conscious or unconscious motivation to align themselves against a stigmatising position.



## **DISCUSSION**

### **OVERVIEW**

The aims of this study were to elucidate social representations of psychology and the psychologist. The content of these representations includes beliefs and emotions profoundly shaped by socio-cultural heritage. These are embedded in the collective discourse of the public and used to make meaning of the phenomena of psychology and the psychologist.

A rich and complex mix of consensual ideas emerged, despite the participants having had no personal contact with psychologists. Moreover, their accounts were additionally suffused with contradictions, uncertainties and ambiguities. From a social representations theory perspective, this suggests that the phenomena of psychology and psychologists have become anchored to a rich and complex socio-cultural history of ideas by association with older, more familiar concepts. This complexity seems to reflect a multiplicity of strands of socio-cultural influence which have been incorporated into the fabric of the social representations carried by the sample. Different threads within this fabric are expressed at different moments by different individuals, according to the current context in which they find themselves.

This chapter will begin by discussing the findings from the study. It will then go on to consider pertinent methodological issues, suggestions for future research and the clinical implications arising from the findings, followed by a summary and some concluding comments.

## **SOCIAL REPRESENTATIONS OF PSYCHOLOGY AND THE PSYCHOLOGIST**

For conceptual clarity, the discussion of the findings of the study has been divided into five sections. The first discusses the consensual ideas which emerged across the sample. The second considers paradoxes and ambiguities in the data. The third and fourth review the salient sex and age differences which were observed, whilst the fifth and final section examines idiosyncratic and absent themes.

### **Consensual findings**

Several aspects of the participants' representations were consensual. By definition, it is the most consensual elements that are most likely to reflect social representations, both within and beyond the sample.

Overwhelmingly, psychology was viewed as a medical discipline, concerned with studying the mind. A few participants mentioned psychology as involving study of the brain, but all of these had also used the more abstract concept of 'mind'. This suggests that the consensus was not to locate psychology as a primarily neurological discipline. In fact, the majority of the sample anchored the psychologist to the psychiatrist and/or a type of doctor. This corroborates research which suggests that psychologists were viewed as most similar to psychiatrists by a US sample (Tinsley et al, 1984). From a social representations theory perspective, this consensual view of psychology as a mind-oriented medical discipline, and the psychologist as akin to the psychiatrist, implies a host of associations with a Western medical culture in general, and the history of mental health issues in particular. These anchoring concepts are now considered in turn.

In terms of associations with medical culture in general, there was considerable consensus amongst the sample in viewing the psychologist as highly educated and as the custodian of expertise which was bestowed upon relatively passive recipients. Many of the participants' accounts were thus suffused with the sense of the psychologist as a knowledgeable and powerful authority. This high status, authoritative theme also emerged when participants spontaneously mentioned the role of psychologists in society, as psychologists were most often associated with forms of social control, particularly institutionalisation. This view supports a recent sociological analysis of the rise of psychology, or "the rise of the expertise of human conduct" (N.Rose, 1996, p.85), in which it is suggested that in contemporary society people are looking increasingly to psychologists "to comprehend and surmount the problems that beset the human condition" (N.Rose, 1996, p.81).

In terms of the linking of psychology with mental health, some strikingly consensual ideas and emotions emerged. The remarkable sharedness of these implicates them as fundamental to social representations of psychology and the psychologist across the sample. The common theme of these was around negative emotion. Much of this was expressed in the almost ubiquitous reaction of fear at the thought of seeing a psychologist, and in the overwhelming use of stigma-oriented discourse in discussing clients. Indeed, it is striking that in attempting to tap into social representations of psychology and the psychologist, one of the most coherent themes to emerge was actually around the issue of what it means to be a client. This issue appeared to be not only one of the most consensual, but also one of the most emotive.

The threat associated with seeing a psychologist, and the stigmatising of those who do, which arose in the present study seem to echo much of the self-report literature reviewed earlier (e.g. Deane & Todd, 1996; Fischer & Turner, 1970; Leong & Zachar, 1999). For instance, many of the specific fears expressed within the sample seem to mirror aspects of the ‘treatment fearfulness’ construct from the TAPS (Deane & Chamberlain, 1995), such as participants’ ‘fear of being thought to be abnormal’ as roughly analogous to aspects of the TAPS factors ‘social stigma concerns’ and ‘image concerns’, and their ‘fear of being analysed’ as roughly analogous to aspects of the TAPS factor ‘coercion concerns’.

From a social representational perspective, the high degree of consensus for the idea of psychology as a mind-oriented medical discipline, like psychiatry, provides a potential explanation for the pervasive theme of negativity. A social representational interpretation is that these anchors link psychology to the rich and emotive socio-cultural history around ‘madness’ (deRosa, 1987). This thereby renders psychology, and all things associated with it, as something to be feared, shunned and avoided (Gilman, 1988; Morant, 1998).

In thinking about psychologists, the participants appeared to be drawing upon a range of ideas about emotional distress which originated during different historical periods. All of these ideas incorporate the notion of deviance from the norm. This view of emotional distress as manifestly different from the norm enables people to feel safely distanced from the fear it evokes in them. This is because they can associate it with other people, in particular people who are different from the norm (Gilman, 1988).

The threat of emotional distress or 'madness' is thus defended against by associating it with 'The Other', with 'otherness' having been labelled historically at different times as 'evilness', 'dangerousness' or 'illness' (D.Rose, 1996). However, within the present study the most commonly used discourse was around the medicalisation of emotional distress. This reflects the most recent mainstream re-conceptualisation of 'madness', when post-Enlightenment thinking redefined it as 'mental illness' (Morant, 1998). By anchoring psychology to 'madness' and medicine, then, the participants were reflecting this socio-cultural definition of 'otherness' as 'illness'.

However, despite this medicalisation of psychological distress, it was also apparent that participants tended to view mental illness as being qualitatively distinct from physical illness. The construction of this distinction, combined with the themes of fear and stigma across the sample, suggests that psychological distress is represented as somehow more unacceptable than physical illness.

A social representational approach would argue that this is due to the original anchoring of the new concept of mental illness in the late 19<sup>th</sup> century, which was done by linking it to older ideas about 'madness', such as the 'madman' as an unpredictable, evil figure and madness as inherently dangerous (Gilman, 1988; D.Rose, 1996). Thus when the participants in this study were using a modern medicalised account, on some level they were also drawing upon previous sensationalised and unpleasant ideas of 'madness', ideas which the media feeds upon and perpetuates (Rose, 1998).

Reflecting, then, upon the most consensual ideas which emerged in this study, it seems that psychology was viewed as both similar to, and different from, a branch of

medicine. The medicalisation of emotional distress and the anchoring of the psychologist to more familiar high status medical professionals has resulted in social representations of the psychologist as a knowledgeable medical authority figure. However, at the same time, psychologists were viewed as different from such figures, because of their association with emotional distress and the mind, which was seen as qualitatively distinct from physical distress and the body. This reflects the Cartesian dualism fundamental to mainstream Western thought (Purkhardt, 1993).

In addition, from a social representational perspective, the links between psychology, emotional distress and the mind have led to the anchoring of psychology to historical ideas about 'madness' which pervade Western culture (deRosa, 1987). As psychology is thereby associated with 'otherness', it is therefore seen as something to be shunned and avoided (Gilman, 1988), hence the commonality of themes of threat and stigma. Thus, in line with social representations theory, the individual participants' beliefs appear to have been constrained and shaped by their shared socio-cultural heritage (Markova, 1996).

Furthermore, as social representations are deemed to serve a function for their carriers (Joffe, 1996b; Wagner, 1996; Wagner et al, 1999), the link between psychology and 'madness' may serve to perpetuate the view of psychologists as powerful experts. This is because people may have an unconscious need to believe that the threat from 'The Other' is under the control of authoritative, knowledgeable, powerful people, and is therefore containable.

### *Paradoxes and ambiguities*

Having discussed the consistent elements of the social representations across the sample as a whole, it is important to consider the apparent paradoxes and contradictions in the data. The use of a qualitative methodology allowed for the emergence of such nuances.

Firstly, following on from the preceding discussion regarding the historical link between psychology, 'madness' and dangerousness, it is interesting to note that, in fact, only a quarter of the sample viewed psychologists as dealing with antisocial behaviour, and only 3 mentioned psychotic behaviour. In contrast, the most commonly mentioned issue was depressive problems, which arose in over half the interviews. This suggests that psychology was more commonly associated with sadness, rather than madness or badness. It is not immediately apparent why such pervasive fear and stigma should be associated with people primarily viewed as depressed.

One possible explanation for this is that the fear and stigma associated with becoming a client is primarily concerned with risk to integrity of the self. A psychodynamic extension of social representations theory, based on Kleinian object relations ideas, gives a possible way of conceptualising how this results in stigmatising behaviour (Joffe, 1999). Initially, such an intrapsychic theory might appear to be epistemologically incompatible with a social representational approach. However, writers from several theoretical perspectives have suggested that social groups enact defensive behaviours analogous to the individual intrapsychic defences of psychoanalytic theories (Gilman, 1988; Joffe, 1996b & 1999).

In Western cultures, the idea of authentic personhood is founded on notions of autonomy and self-regulation (Turner, 1986). Being unable to cope for oneself or losing the ability to control oneself are therefore highly threatening because they are perceived as indicative of the disintegration of oneself as a person. People observing the loss of these abilities in another, such as somebody who shows depression, are thereby reminded of their own vulnerability.

Within a Kleinian conceptual framework, it is suggested that this anxiety is warded off by the use of the primitive unconscious defence mechanism of 'splitting', whereby the 'badness' associated with one's own vulnerability gets projected into the other person. The Other is then viewed as 'bad', whilst The Self retains the 'good', and is thus protected from feeling threatened. In Kleinian terms, this is referred to as the 'paranoid-schizoid position'. The Other then becomes viewed as dangerous, because it is fantasised as carrying the projected aggression associated with loss of control.

The aim of this projection is not just to get rid of the 'bad', but to locate the source of danger such that it can be controlled. In order to control it, and to avoid the risk that the 'bad' parts will spill into the 'good', The Other becomes shunned, stigmatised and the subject of social control measures. This sense of The Other as contaminated and contaminating is thus driven by an unconscious need to maintain 'goodness', order and control associated with The Self.

Previous social representations research has illustrated this implicit sense of contagion in the way that French villagers refused to use the same cutlery as their lodgers who were labelled as mentally ill (Jodelet, 1991). There was also some suggestion of it in the present study, in the expressions of wariness regarding clients which did not appear to



be due to a fear of violence. Indeed, one participant explicitly drew an analogy between wariness of clients and wariness of infectious diseases.

As well as the drive to preserve positive feelings about The Self, it is argued that there is a Western tendency for unpleasant consequences to be attributed to the victim – the so-called ‘just world hypothesis’ (Furnham, 1985). The ‘just world hypothesis’ is defensive because it plays down the unpredictability of the world and further justifies the stigmatisation of people who have been shunned for carrying projected threat. It is as if, on an unconscious level, it is deemed that people who seem to be losing their ability to cope and losing their self-control must have somehow brought this on themselves, and because of this and their show of vulnerability they are seen to be deserving of stigma. However, what is really being avoided is the confrontation with The Self’s possible vulnerability (D.Rose, 1996), and instead the focus is on the derogated, yet threatening, Other (Joffe, 1996b & 1999).

This explanation accounts for why the majority of the participants in this study produced stigma-oriented responses to the idea of being a client of a psychologist, whilst simultaneously viewing clients as primarily depressed: they needed to see clients as different to themselves because clients’ suffering is associated with an unconscious fear of psychic collapse. On an unconscious level, the maintenance of this difference served to contain participants’ anxiety by labelling clients as the cause of it.

However, it is also necessary to account for the observation that around a third of the participants who used stigma-oriented discourse additionally expressed positive views regarding clients. Continuing the use of a Kleinian framework, this can be understood as the more mature ‘depressive position’, in which toleration of ambivalence has developed.

In this 'depressive position', objects, including The Self and The Other, can be viewed as possessing both 'good' and 'bad' aspects simultaneously (Klein, 1952). The 'depressive position' is not seen as replacing the 'paranoid-schizoid position'. Rather, it is proposed that sufficient threat will cause people's responses to regress back to the more primitive split view. The occurrence of this is likely to be amplified by the extent to which currently circulating social representations contain, reinforce and provoke this polarised position.

The results of this study suggest that an additional discourse of tolerance and acceptance of clients was apparent in a substantial minority of the sample. Compared with earlier representations of 'the mad' as something to be avoided, within a Kleinian interpretive framework this additional discourse is conceptualised as the emergence of social representations which hold the 'depressive position'. This finding may be among the first of its kind, as it contrasts with recent claims that there is, as yet, little evidence for a new social ideal of acceptance of mental health service clients as affirmed members of society (Morant, 1998).

This highlights the value of using a methodology which allows for the emergence of additional discourses. Standard questionnaire approaches tend to impose linear reasoning, and so do not readily allow for the both/and position, i.e. seeing clients in both a positive and a negative light, as they are more likely to involve forced choice between being either positive or negative about clients. They thus inhibit the identification of multiple discourses which might be crucial to a full understanding of the phenomena under investigation.

The discussion so far has focused on the observation that participants seemed to be associating psychologists' clients with the collapse of a sense of self, and so anchoring them to the history of ideas about 'madness' explicated in previous literature (e.g. deRosa, 1987; Gilman, 1988; Jodelet, 1991; Morant, 1998; D.Rose, 1996; Rose, 1998; Wahl, 1995). However, it is particularly interesting in the context of the present study that, in at least some cases, this association appeared to have spread to the participants' views of psychologists themselves. There was evidence, therefore, that psychologists themselves were stigmatised.

Two processes appeared to be at work. Firstly, stigma was expressed in participants' desire to avoid psychologists for fear of being analysed and found to be abnormal. Secondly, it seemed that the process of anchoring the psychologist to ideas about 'madness' had resulted in the psychologist, too, becoming a target for the projection of anxiety-provoking feelings, and thus represented as a negative Other. This sense that the 'bad' associated with being a client had spilled over and tainted the psychologist was apparent in expressions of the view that psychologists were 'weird' or 'abnormal' in some way. In terms of the social representational process of 'objectification', this abstract view of psychologists as weird because they are anchored to, and associate with, weird people even seemed to have been concretised by one participant in her use of the 'mad scientist' as a symbol for the psychologist.

However, there was also evidence of the more tempered 'depressive position' in relation to representations of the psychologist, as several participants expressed both negative and positive views of the personality characteristics of the psychologist.

Whilst more negative than positive views of the client were expressed across the sample, the reverse pattern appeared to be the case for the personality characteristics of the psychologist. In addition, although the psychologist was generally seen as a threatening figure, comments regarding the usefulness of such a figure were more often positive than negative. This was possibly motivated by the participants need to believe that psychic disintegration was controllable through treatment, thereby lessening the threat with which it is associated.

In addition to the more negative portrayals of psychologists as weird from a minority of participants, some of the sample also cast aspersions regarding the value of psychologists in terms of their competence and the ethics of what they do. This fits with previous research on therapists in films, which found that a substantial minority were presented as incompetent or nefarious (Schneider, 1987). These converging findings from both visual and verbal media strengthen the idea that current social representations of psychologists contain a negative element, because public media such as films are deemed to be major carriers and perpetuators of social representations (Bauer & Gaskell, 1999). This doubting of the competence and motives of psychologists may reflect an unconscious fear of the power of 'madness' and a wish for it therefore to be left alone.

The next set of apparent paradoxes to be considered concerns participants' explanations for the problems psychologists address. This is of particular importance as the existing literature suggests that the models of psychological distress people hold drive their response to their problems (Fisher & Farina, 1979). The present study sheds some light on what types of models are used amongst the public.

The first point to note is the multiplicity of contradictory explanations for psychological distress that were used, both across and within individuals. Recent external events, distal (often childhood) events and physical causes were the three main categories of aetiological model that emerged, each mentioned by around a quarter of the sample. Although psychological problems were most commonly attributed as internal to the individual in some way there was still a substantial proportion of the sample who used external attributions. Amongst these differing explanations for psychological distress, some co-occurrence of ideas was apparent, in that around a quarter of the participants used more than one type of aetiological model, and a quarter used both internal and external attributions.

From a social representational perspective, this is presumed to reflect the multiplicity of competing explanations for psychological distress (Eisenberg, 1977) which exist within the socio-cultural heritage of the sample. For example, one of the historical discourses that did emerge was the attribution of psychological problems to an inherent weakness in the individual, perhaps originating in the idea of mental distress as being due to 'feeble-mindedness', an inherited weakness of the brain proposed by biological psychiatrists prior to the First World War (Pilgrim & Treacher, 1992). There was also evidence of medicalisation of distress (deRosa, 1987; D.Rose, 1996) and of the dissemination of psychodynamic ideas regarding the impact of childhood on later well-being (Moscovici, 1976). All of these historical notions co-existed in the sample alongside more contemporary ideas about the role of externally generated stress in affecting psychological well-being.

Each of these competing discourses on aetiology assigns different weightings to internal and external attributions for problems. For example, feeble-mindedness and medical aetiological models tend to locate problems within the biology of the individual; psychodynamic models locate problems within the mind of the individual, but assume that this has been caused by external forces during childhood; stress models focus on the impact of stressful experiences on essentially 'normal' people, with the idea that everyone has their breaking point.

Mental health services have attempted to encapsulate parsimoniously the most useful aspects of these multiple models within the unitary, yet multifactorial, 'biopsychosocial model' (Marzillier & Hall, 1992). However, recent research suggests that there is collective uncertainty and mixing of multiple models amongst mental health professionals (Gaines, 1992; Kirk & Kutchins, 1992; Morant, 1998) and amongst clients of mental health services (Pistrang & Barker, 1992). Explanations for the psychological problems given by participants in the present study mirror this lack of coherence. This is also in line with previous research which suggested that lay people use different types of formulation to understand different problems (Furnham, 1997; Furnham & Hayward, 1997). In social representational terms, this uncertainty amongst clinical and non-clinical samples is deemed to reflect the dissemination of uncertainty from society's experts, in this case mental health professionals (Morant, 1998).

In line with this notion of dissemination from expert to public, it seemed that the ways in which participants explained clients' problems reflected the dimensions of difference, distress and disruption which professionals use (Morant, 1998).

The themes of difference and distress seem to have evolved historically from medical and psychoanalytic discourses, which conceptualise 'psychotic' phenomena as qualitatively different to so-called normal experiences, and 'neurotic' phenomena as a quantitatively greater version of normal distress. The theme of disruption adds an essentially social dimension to conceptualisations, as clients' problems are at least partly defined in terms of disrupted social functioning.

As well as emerging in some individual accounts, the qualitative/quantitative distinction and the social dimension of disruption were also apparent across the sample in terms of the types of generic labels used for clients' problems, e.g. mental problems/illness versus distress versus coping difficulties.

Complexity and uncertainty are therefore apparent in the conceptualisations of the present sample, other non-clinical samples (Furnham & Hayward, 1997), clinical samples (Pistrang & Barker, 1992) and so-called mental health experts (Morant, 1998). This seems to reflect the multiplicity of often contradictory models (Eisenberg, 1977), the inherent ambiguity of historical qualitative/quantitative distinctions (Gelder, Gath & Mayou, 1989), and the apparent paradox associated with using social criteria to define problems which are then dealt with by medical professionals (Morant, 1998). This tangle of ideas seems to reflect the fundamentally intangible nature of psychological distress (D.Rose, 1996).

The discussion so far has illuminated the emergence of a paradoxical view across the sample: participants seemed to be representing psychologists as professionals who, despite being seen as medical experts, nevertheless were seen as dealing with problems which are not construed in traditionally medical ways. Adding to this paradox is the

observation that almost half the sample, whilst viewing the psychologist as a high status medical expert, also anchored the psychologist to non-professional informal helpers, such as family, friends, advisor, mentor, role model. It seems unlikely that this would be the case for other more traditional medical professionals. This paradoxical theme develops further when we consider participants' views on psychological treatments, both in terms of how they are presumed to work and what they entail.

In terms of the therapeutic effect of psychology, around two thirds of the sample attributed this to some type of expert intervention done for or to the client, who was therefore seen as a relatively passive recipient. This directly mirrors a traditional medical model of care in which the only input required from the client is to adhere to the prescribed treatment. However, the main 'prescribed treatments' mentioned in the present study were that the psychologist would give advice to be followed, or that the psychologist would solve the client's problem for them, neither of which are traditional medical interventions. Indeed, only 3 participants expressed the belief that psychologists give medication. In line with this, the work of the psychologist was described by the majority of participants in terms of attentive communication processes, such as talking, listening, questioning and delving into the client's mind, and not in terms of physical examinations or investigations, as might be the case for other medical experts.

Although around a third of the sample mentioned only 'expert' models of care, another third of the participants highlighted, in addition to this, the importance of collaboration between psychologist and client for the therapeutic endeavour to be effective. This contrasts with a traditional medical model of care in its emphasis on the active participation of the client in contributing to the treatment. Furthermore, this finding



fits with the results of previous research in which lay people endorsed the role of individual effort, as well as the importance of professional help, in overcoming psychological problems (Furnham & Hayward, 1997).

These results suggest that, although psychologists are primarily represented as medical experts, there is an emerging discourse which acknowledges psychological treatment as an essentially social endeavour in which views of ‘psychologist as expert’ and ‘psychologist as collaborator’ co-exist. In social representational terms, this may be the consequence of the dissemination of professionals’ ideas about treatment, as it seems they, too, construe their work in broadly social, rather than medical, terms (Morant, 1998).

### **Sex differences in social representations of psychology and the psychologist**

Having discussed the general consensus and paradoxes apparent across the sample as a whole, the salient differences that emerged between men’s and women’s representations are now considered.

Both sexes expressed a sense of being threatened at the thought of seeing a psychologist and showed this in a number of ways. However, more men than women did this by means of a hostile response, with a denial of need. In contrast, more women than men expressed their sense of fear in terms of feeling hurt or upset. Women also more commonly expressed emotions other than threat at the thought of seeing a psychologist, such as feeling interested, relieved or in awe. Although stigma-oriented discourse regarding clients was common throughout the sample, women more often than men directly acknowledged the issue of stigma in society and aligned themselves against it. In

addition to this greater reflexivity, women also spontaneously generated a greater number of positive representations of clients than did the men, who tended to present an apparently neutral stance.

These findings suggest that the men and the women positioned themselves differently relative to feelings of threat and responses to being a client. Social representations theory argues that the function of social representations is to defend against perceived threat (Joffe, 1996b & 1999). The social representations that people carry are thus shaped by the identity that they seek to protect. Gender identity seems to develop from a very early age and is thus intimately connected with the development of one's sense of self and social identity (Goldner, Penn, Sheinberg & Walker, 1990; Wagner et al, 1999; Young, 1984). It is argued that a typically Western male gender identity places great importance on rationality, courage and strength of will (Lorenzi-Cioldi, 1996; Warren, 1982). The collapse of rationality and self-control, which the earlier discussion has suggested is associated with seeing a psychologist, is thus more fundamentally threatening to men's sense of self and personhood than it is to women. It seems, then, that the men's social representations were shaped by their need to protect their sense of gender identity.

The Kleinian framework used earlier provides a possible explanation for how this protection of gender identity was manifested in the participants' accounts. According to Klein, greater threat encourages greater regression to more primitive forms of defence, such as splitting and projection. The women's capacity to directly acknowledge the issue of stigma, to respond more positively regarding clients, not to immediately dismiss the suggestion of going to see a psychologist, despite finding it somewhat hurtful, and,

indeed, to express some interest and relief at the possibility suggests their greater ability to tolerate feelings of ambivalence, and thereby to adopt the 'depressive position'. In contrast, the greater threat posed to the men's sense of identity seemed to maintain them in the more split 'paranoid-schizoid position'.

Furthermore, the typically Western female gender identity idealises empathy and taking care of others, and incorporates ownership of vulnerability (Goldner et al, 1990; Ussher, 1997). The women participants' sense of gender identity is therefore likely to have amplified their capacity to retain this 'depressive position'.

This explanation for the sex differences in the present study in terms of protection of gender identity through the use of Kleinian defence mechanisms would also account for previous research, which has repeatedly found that men are less likely than women to seek psychological help and more likely to hold negative attitudes towards it (Deane & Todd, 1996; Fischer & Turner, 1970; Kushner & Sher, 1991; Leong & Zachar, 1999; Wills & DePaulo, 1991).

This theoretical explanation for the observed sex differences is further strengthened by the observation that more women tended to view psychologists as having positive personality characteristics, whereas more men tended to attribute them with negative personality traits. This fits with the notion elaborated earlier that, because psychologists are anchored to, and associate with, people who are considered weird, they become labelled with the negative characteristics that have been projected onto their clients. It is argued that this labelling was used less by the women, because of their 'depressive position', and was more apparent amongst the men, because of their

motivation to use projection as a defence to protect their group identity, in this case their gender identity.

Furthermore, despite the consensus view across the sample as a whole of psychologists as medical professionals, more of the men appeared to be denying a niche for psychologists, perhaps as a way of further distancing themselves from threat. Thus the men more than the women tended to question the usefulness of psychologists, seeing them as having a similar role to that of friends or family. In contrast, the women tended to see psychologists as useful and as having a role distinct from that of friends or family, somewhat akin to a counsellor, but with more expertise.

In addition, the men showed a greater tendency to use internal attributions for the locus of problems compared to the women. Perhaps this was a further reflection of their desire to maintain a view of the threat as located within The Other, who can then be controlled and contained. Conversely, the women showed greater use of external attributions for problems and more commonly highlighted the role of personal experiences and relational events in aetiology. This suggests that they were less threatened by the idea that people's psychological well-being can be subject to external contingencies, because they were less threatened by the idea of personal vulnerability than were the men. However, a feminist approach might argue that the greater use of internal attributions by the men reflects a wish not to implicate forces in a society in which they are the dominant voice as being potentially problematic (Ussher, 1997).

Finally as regards sex differences, it is interesting how the different sexes viewed psychologists as addressing certain specific problems more commonly associated with their own sex (Ussher, 1997). Social representations theory would argue that this is

because group identity shapes people's representations (Joffe, 1996b). Thus women more often than men mentioned children's problems and so-called 'nervous breakdown', whereas men more often than women mentioned antisocial behaviour. However, this finding amongst the men may also reflect their increased sense of threat and need to locate psychological problems within the 'bad' Other.

### **Age differences in social representations of psychology and the psychologist**

Salient age differences in representations were less common than salient sex differences within this sample. However, a few interesting age differences emerged.

Although a sense of threat at the thought of seeing a psychologist was common across the age groups, the older participants more often expressed this as a fear of being thought abnormal in some way, whereas the younger participants more often mentioned a fear of being analysed. On further consideration, this fear of being analysed generally seemed to be underpinned by a fear of the outcome of being analysed. This suggests that both older and younger participants alike feared that seeing a psychologist might lead to being labelled as mentally abnormal, which, as already discussed, constitutes a fundamental threat to the self.

Although the majority of the sample located psychology within a medical discourse, more older participants than younger ones tended to propose brain dysfunction as an aetiological mechanism for psychological problems, and to attribute such problems as being due to a deficit in the brain or the mind of the individual. This perhaps suggests that the older participants' representations tended to be more shaped by the older

historical discourse of mental distress as being due to 'feeble-mindedness' (Pilgrim & Treacher, 1992).

In contrast, more younger participants than older ones viewed psychological problems as being due to a medical illness and/or the role of personal experiences. This suggests that the newer discourse of medical illness may be more influential in younger cohorts than the older discourse implicating inherited brain weakness (Pilgrim, 2000; Pilgrim & Treacher, 1992). Furthermore, ideas from psychoanalytic thinking and social learning theory seem to have had more influence within the younger cohort, as they showed a greater tendency to highlight the role of personal experiences.

These findings therefore suggest that the younger participants were more likely to view problems in terms of an eclectic range of possible medical and social triggers. This is in line with current representations held by mental health professionals (Morant, 1998). In social representational terms, this suggests that this professional view is filtering through to the public and being incorporated into the representations of primarily the younger generations.

This dissemination of ideas from mental health professionals to the younger generation was also apparent in how the different age groups tended to view the therapeutic effect of psychology. More older than younger participants attributed the therapeutic effect solely to the expertise of the psychologist, whereas more younger than older participants additionally endorsed the active participation of the client and the importance of collaboration.

Within a social representational framework, this suggests that the older participants' representations may be generally more influenced by their ideas of mental

health care in the style of the old asylums, where professionals were authoritarian experts and sufferers were silent, passive, disempowered patients. However, the younger participants' representations additionally appeared to incorporate more contemporary ideas about the need for client participation in order to effect change. This emerging representation of 'psychologist as collaborator' is perhaps drawn from the newly emerging culture of psychological self-help, associated with the increasing 'psychologising' of society (N.Rose, 1996), as well as from ideas about what makes for effective treatment which are diffusing out from professional spheres (Morant, 1998).

This new 'psychologising' of society is perhaps also reflected in the finding that more younger than older participants expressed interest or intrigue at the thought of meeting with a psychologist (Kunkel & Williams, 1991), and that the only participants to use the term 'therapist' were from the younger age group.

Furthermore, this 'psychologising' of society may mean that younger people now tend to view psychology as a more mainstream discipline. This is suggested by the observation that the few participants who explicitly anchored psychology to science in addition to medicine were from the younger age group. In contrast, there may be a tendency for older people to view psychology as a more fringe discipline, as the two participants who anchored psychology to complementary medicine in addition to Western medicine were from the older age group.

In terms of specific problems, older participants mentioned dementia more, presumably because its particular relevance to their age group had shaped their representation. They also used terms such as 'stress' and 'worry' more than the younger participants. Younger participants mentioned depression more often than older

participants, perhaps due to its increased media profile in recent years, for example with the 'Defeat Depression' campaign. This increased public profile may mean that terms like 'stress' and 'worry', as used by the older participants, have become replaced by the term 'depression'. Older participants also mentioned antisocial behaviour more often than younger participants. Perhaps this reflected a greater adherence to the older discourse about psychological distress serving to make people dangerous (deRosa, 1987; D.Rose, 1996).

Previous research has found that, within a US sample, older and younger people reported similar expectations about counselling (Kunkel & Williams, 1991). However, within the present study's UK sample, although the older and younger participants did show considerable consensus across many aspects of their representations of psychology, there were a few differences. Some ideas can therefore be proposed regarding previous findings that older people seem to be less favourably disposed towards psychology and mental health services (Furnham & Wardley, 1990; Hopson & Cunningham, 1995; Leaf et al, 1987).

It is suggested that the crux of the matter is the meaning attached to seeking psychological help and becoming a client (Kunkel & Williams, 1991). Both age groups seemed to feel similarly threatened by the thought of seeing a psychologist. However, perhaps the co-existence of feelings of interest and a view of psychology as more mainstream allows younger people to have the more positive overview of psychology implied by previous research (Furnham & Wardley, 1990; Hopson & Cunningham, 1995; Kunkel & Williams, 1991). In addition, the results of the present study suggest that older people may have a greater tendency to attribute psychological problems solely to an



inherent weakness within the individual, and that seeking help would be to admit to this. Instead, the socially acceptable course of action for them, inherited from war-time mentality, is likely to be self-reliance and 'stiff upper lip'. Furthermore, it is suggested that older people may have a more 'expert' view of psychologists than younger people, and that, as a cohort effect, they are perhaps more likely to associate such experts with the old style punitive and authoritarian regime of the asylum.

In the light of these suggestions, the previous findings cited above, which suggest that younger people view psychology more favourably than older people, are perhaps not surprising.

#### **Presence, or absence, of additional representations**

Social constructionists have argued that what is absent from a text is as important as what is present (D.Rose, 1996; Wagner et al, 1999). Given the increased 'psychologising' of society and the associated "rise in the expertise of human conduct" (N.Rose, 1996, p.85), it is therefore of interest that the overwhelming consensus within the present study was to view psychology as a clinical discipline concerned with the breakdown of mental health. Although a few participants also referred to education, occupational selection and clinically-oriented research, a broader representation of psychology as the overall study of human functioning and interaction was absent.

However, this may have been influenced by the preliminary information sheet given to the participants, which made reference to one of the researchers as belonging to the Sub-department of Clinical Health Psychology and to the fact that the study had been approved by a hospitals-based research ethics committee. In addition, the researcher had

verbally been introduced as working for the NHS and some of the interview questions were worded in such a way as to imply a clinical context to a certain extent, e.g. “If you heard that someone you knew had seen a psychologist, what would be your reaction?”. Nevertheless, participants did seem to anchor the subject area as a clinical one from the outset, even with their answers to the first, very general, question, i.e. “When I say the word ‘psychologist’, tell me what’s going through your mind?”.

Thus the sense is that participants’ social representations were genuinely based around human mental health, rather than having a broader remit, incorporating aspects of other branches of psychology. In the UK, prior to the emergence of clinical psychology from under the auspices of psychiatry, psychology as a discipline had been largely an academic endeavour with which the public had little or no contact (Hall & Marzillier, 1992; Pilgrim & Treacher, 1992). This provides a socio-cultural rationale for the public’s anchoring of psychology to the area of human mental health, in that, historically, the interface between psychology and the public first occurred primarily via clinical contexts.

It is also salient that, in light of the recent explosion of interest in self-help, personal growth and ‘pop psychology’, the explicit idea of psychology as a framework for guiding a laudable journey of self-discovery was largely absent from the present study. This appears to contrast with findings from a study of young adults in the US (Kunkel & Williams, 1991). This is perhaps a reflection of the demographic profile of the present UK sample. Most of the participants had left school with few qualifications and worked in, or were retired from, unskilled or semi-skilled jobs. They are therefore perhaps less likely to have been as influenced by ‘pop psychology’ as would other

demographic groups, for whom reading and self-exploration might be more of a subcultural norm.

However, implicit in a minority of accounts were some positive ideas regarding the notion of psychology as a potentially interesting and helpful collaborative venture. This suggests that the increased public profile of psychology, including the influence of the 'pop psychology' genre, may be starting to have some impact, which would be expected to influence future social representations of psychology. Nevertheless, as regards the present study, the low proportion of both positive responses to the idea of seeing a psychologist and positive views about clients suggests the continuing dominance of pathologising representations, at least within this sample.

This implies that people who currently go to see psychologists may be a self-selected group who hold more positive representations. On the other hand, they may hold similar representations to this sample. If this is the case, this suggests that, as was discussed by participants in the present study, visiting a psychologist may tend to add to people's distress by triggering quite negative self appraisals, because people feel that they have been unable to cope with their problems by using more acceptable options.

Given this sense of the psychologist as a last resort for people desperately seeking help, it is interesting how few participants mentioned the importance of the client opening up to the psychologist and of the engendering of trust. Furthermore, only one participant spontaneously expressed the belief that the psychologist and the client needed to 'click' with each other for treatment to be effective. These observations suggest that professional ideas about the importance of the therapeutic alliance (Arkowitz, 1997; Stricker, 1994; Wright & Davis, 1994) have yet to percolate into the public domain.

This absence of ideas about the therapeutic relationship appears to be at odds with the finding that almost half the sample anchored the psychologist to informal helpers with whom they would be presumed to have a trusting relationship, such as family, friends, advisor, mentor, role model. However, more than half the sample made no such link. This suggests that there is perhaps an implicit assumption of a trusting, and somewhat intimate, professional-client relationship within the representations of the participants who did anchor the psychologist to these kinds of informal helper.

As regards representations of the psychologist, it is interesting how few participants used 'shrink', 'therapist' or 'psychoanalyst' as anchor figures. This suggests that these terms are not as commonly used amongst the British public as might be the case in the US. However, this may change with the current American penchant for producing films and television dramas with therapy as the subject which are then subsequently released in the UK. Recent examples include the films 'Good Will Hunting', 'Analyze This', and 'Sixth Sense', and the drama series 'Ally McBeal'.

Finally, there were some observed absences in terms of the aetiological models expressed by the sample. The citing of systemic or social causes was almost absent. This appears to be a reflection of the individualisation of distress endemic to Western cultures (Turner, 1986). Feminist writers have argued that this serves to maintain the status quo for the continuing benefit of the dominant and most powerful groups in society, in that, if distress is individualised, the social systems over which they have control are not implicated as potentially problematic (Ussher, 1997). In addition, if the threat of psychological distress were to be located within the systems of society, which impact on everyone, it would consequently be seen as uncontrollable, hence rendering a view of

The Self and an ordered society as potentially dangerous (Gilman, 1988). A psychoanalytic stance would suggest that by individualising it, thereby locating it within certain individuals, it can be controlled and contained.

Also, the contemporary trend for reducing the aetiology of problems to the level of genetics (Roberts & Claridge, 1991) was almost absent from the sample's representations. The idea that psychological problems could be biologically inherited was almost completely absent, despite the dominance of medical and individualising representations within the sample. This suggests a possible implicit assumption of the role of nurture in the development of psychological problems.

Finally, none of the participants expressed the idea that people with psychological problems are inherently evil. Notwithstanding the fear and stigma throughout the sample concerning the concept of psychic disintegration, this nevertheless suggests that this old 17<sup>th</sup> century notion of innate wickedness has been considerably re-shaped by more modern discourses (Gilman, 1988; Morant, 1998; D.Rose, 1996; Rose, 1998).

### **Summary of main findings**

The aims of this study were to investigate the social representations of psychology and the psychologist amongst a sample of the general public. Despite being set up specifically to examine variability across the four demographic groups, the degree of consensus across the sample as a whole was striking. However, the use of qualitative methodology also allowed for the emergence of paradoxes and seemingly contradictory themes important in enriching understanding.

The vast majority of the participants seemed to hold social representations of psychology as a clinical discipline associated with mental health, and of psychologists as high status medical professionals, akin to psychiatrists or doctors, who are experts in the study of the mind.

Multiple models of the nature of psychological problems emerged. The principal emphases in these were on individual factors and the role of personal experiences, with little or no attribution of psychological problems as being due to innate 'wickedness', biological inheritance or systemic factors. Most participants viewed the psychologist's expertise as the primary therapeutic agent, with little direct emphasis on the therapeutic relationship.

There were overwhelmingly pervasive themes of threat and stigma associated with seeing a psychologist, consistent with findings from previous research (Barker et al, 1990; Bland et al, 1997; Hoeger, 1995; Madianos et al, 1993; Rickwood & Braithwaite, 1994; Savaya, 1998; Veroff et al, 1981). These themes were interpreted psychoanalytically, as forms of defence against the unacceptable prospect of psychic collapse. Only a minority of participants, mainly women, also viewed seeing a psychologist as a potentially positive move, which suggests the contemporary 'pop psychology' culture, which applauds self-discovery, has made little major impact, at least amongst this sample.

Various strands of evidence converged to suggest that the men felt more threatened than the women. It was suggested that this was because psychic collapse is more threatening to men's gender identity, which is fundamental to sense of self. This explanation was put forward to account for previous findings suggesting that women are

more amenable to the concept of professional psychological help (Deane & Todd, 1996; Fischer & Turner, 1970; Kushner & Sher, 1991; Leong & Zachar, 1999; Modcrin & Wyers, 1990; Wills & DePaulo, 1991)

Older and younger participants expressed generally similar ideas of threat, stigma and the nature and role of the psychologist's expertise. However, in the younger cohort there was more evidence that these ideas co-existed with other notions: psychology as more mainstream; psychological problems as being due to external as well as internal factors; meeting a psychologist as being potentially interesting as well as threatening; psychological treatment as requiring collaboration as well as psychologist expertise. The inclusion of these additional discourses within social representations in younger people was proposed as the explanation for previous findings suggesting that they hold more positive views about psychology than older people (Furnham & Wardley, 1990; Hopson & Cunningham, 1995; Kunkel & Williams, 1991).

### **METHODOLOGICAL ISSUES**

The traditional ways in which quantitative research is evaluated cannot be smoothly translated into the domain of qualitative research (Barker, Pistrang & Elliott, 1994; Elliott et al, 1999; Yardley, 2000). Qualitative researchers are therefore developing their own analogous frameworks with which to assess the rigour and credibility of qualitative work (e.g. Elliott et al, 1999; Smith, 1996; Yardley, 2000). Not surprisingly, there is considerable overlap between the criteria suggested by different writers. For the purposes of evaluating the present study, then, the seven evolving guidelines proposed by Elliott et al (1999) will be used. These have been chosen as they are the result of recent

and extensive discussion and collaboration amongst a considerable network of qualitative research exponents.

1) *Owning one's perspective*

The first guideline concerns the researcher owning their own methodological, theoretical and personal perspectives relevant to the research. The methodological perspective of the current study has been presented as content analysis (Berelson, 1952; Holsti, 1969; Krippendorff, 1980), and the theoretical perspective as social representations theory (Moscovici, 1984). The researcher's personal perspective was made explicit in the 'Method' chapter, so that the reader could bear in mind the impact that this might have upon the research process.

2) *Situating the sample*

As well as the inclusion criteria for the sample, the present study has included basic demographic data, in order that the reader could get a 'feel' for the sample. Moreover, bearing in mind the impact of the research context on the data that are obtained (Banyard & Hunt, 2000; Yardley, 2000), details were included as to the manner of participant recruitment, the location of the interviews and the presentation of the researcher.



### 3) *Grounding in examples*

Numerous quotes were presented throughout the 'Results' chapter in order to illustrate and justify the development of the coding frame and the interpretations of the findings.

### 4) *Providing credibility checks*

This category represents the qualitative equivalent of reliability and validity. Elliott et al (1999) suggest four possible methods for checking credibility. Firstly, they suggest checking one's understanding of the data with the original participants or others similar to them, which was not done in the present study. Such a reflexive focus on the participants is more common in discursive research approaches (Smith, 1996).

Secondly, Elliott et al (1999) suggest using multiple researchers, an additional analytic 'auditor', or the original analyst to verify the results by review. In the present study a second psychologist independently coded four of the transcripts, which was 12.5% of the data. The resulting agreement was satisfactory, but could have been improved by further discussion of the subtleties of the coding frame, or by merging together some of the more fine-grained categories. It would also have been useful for the researcher to re-code at least some of the transcripts as a means of verifying the results by review.

Thirdly, it is suggested that credibility can be checked by comparing two or more qualitative perspectives as way of gaining a richer or fuller perspective (Smith, 1996). This could have been done by the additional use of other methodologies to investigate social representations of psychology (Bauer & Gaskell, 1999; Wagner et al, 1999).

Although this was not incorporated into this study, the findings here do concur with previous qualitative work on related issues (e.g. Jodelet, 1991; Rose, 1998).

Alternatively, a different qualitative approach could have been incorporated (Barbour, 1998). For example, despite efforts to be transparent regarding the reporting of contextual issues and personal perspective, one possible criticism of this study is that it does not include an analysis of the effects of these issues on the resulting data. Many qualitative researchers argue for the explicit acknowledgement and discussion of how the presence of the researcher and the context of the research process can affect the phenomenon being studied (Smith, 1996). Discursive qualitative approaches argue that “discourse does not occur in a social vacuum” (Gill, 1996, p.142). Participants in research interviews, just like participants in all human interactions, are thus seen as constructing their discourse to fit the particular parameters of the social context. This means that instead of focusing on the content of a participant’s discourse, and thereby seeing discourse as a reflection of an underlying social or psychological ‘reality’ for the participant, the focus is on how the participant constructs his or her account and for what function (Antaki, 2000). Language is therefore not seen as merely a way of sharing views and descriptions with other people, but as a form of action in its own right.

It can be argued that it was beyond the scope of the present study to include a discursive standpoint, with the epistemological shift that this would have entailed (Woolgar, 1996). The assumption in the present study is that social representations, which are embedded in what people say, are, indeed, social constructions. However, the content of what is said is seen as reflecting a subjective position which maintains some degree of consistency and continuity (Henriques, Hollway, Urwin, Venn & Walkerdine,

1998; Joffe, 1999). This is in contrast to discursive approaches in which the notion of subjective experience is absent, and individual responses are seen as the consequence of shifting between particular discursive positions, so that “rather than being a coherent entity, the ‘self’ is ‘nomadic’”(Joffe, 1999, p.9).

Nevertheless, despite epistemological differences between social representational and discursive approaches, it was possible to include some of the elements of reflexive practice advocated by qualitative researchers in general, and discursive approaches in particular (King, 1996; Smith, 1996). These consisted of the researcher’s initial decision to downplay her professional status by introducing herself to participants as a ‘clinical researcher’, rather than as a psychologist, and by dressing casually. This was a deliberate attempt both to minimise the power differential between researcher and participant (King, 1996), and to avoid the difficulties of asking people to discuss with a psychologist their views on psychology and psychologists.

The second element of reflexive practice was the reporting of both the researcher’s personal perspective and the contextual issues discussed above. This gives the reader an opportunity to hypothesise as to the influence of these on the data obtained, and the possible functions of the discourses that did emerge.

In terms of the latter, some participants appeared to be using discourse to paint themselves in a positive light, for example participants who, at times, positioned themselves as positive or neutral, rather than stigmatising, with respect to clients of psychologists. In many of these cases, this seemed to fade as the interview progressed, perhaps suggesting that the interviewer’s use of discourse to maintain an interested and non-judgmental position enabled participants to feel comfortable in shifting to the use of

discourse to stigmatise. In contrast, some participants initially expressed strongly negative views from which they later backed down. In these cases the participants appeared to be using discourse to protect the interviewer's feelings.

The inevitable power imbalance in the interview situation (Yardley, 2000) may have impacted upon the younger men in particular. Several of them initially appeared to be reluctant to speak, and seemed to be using a discourse of ignorance to avoid 'getting it wrong'. In contrast, one younger man appeared to be using a discourse of psychological jargon as a way of re-dressing the power imbalance by portraying himself as knowledgeable. Perhaps the interview situation was particularly unusual for the younger men in that it consisted of a woman of similar age to themselves who was, nevertheless, in a more powerful position as 'researcher'.

One of the methodological limitations of the present study is that it does not explicitly encompass this kind of interpretive stance, despite its implications for the results obtained and the conclusions that can be drawn from them (Smith, 1996). Furthermore, as discursive approaches focus on the centrality and function of conflict and contradiction within discourse (Potter, 1996), this would have allowed for a different way of thinking about the paradoxes within the participants' accounts.

The final credibility check proposed by Elliott et al (1999) is 'triangulation' with quantitative data as a means of providing supporting evidence for the accuracy of the claims (Smith, 1996) and compensating for the limitations of any one method (Barker et al, 1994; Kunkel & Williams, 1991). Although this was not done in the present study, the strength of the findings is supported to some extent by their convergence with the

quantitative work cited earlier (e.g. Deane & Todd, 1996; Furnham & Hayward, 1997; Leong & Zachar, 1999; Pistrang & Barker, 1992; Tinsley et al, 1984).

#### 5) Coherence

This criterion concerns the extent to which the data is presented within a systematic and coherent framework, whilst preserving nuances. This was addressed firstly by presenting the results within two main sections, corresponding to the two main research questions. The coding frame which underpinned these sections, and the subsequent interpretations elaborated earlier in this chapter, have attempted to go beyond a simplistic listing of what was said, in order to make coherent conceptual sense of the findings. The identification and discussion of contradictions and paradoxes in the data, as well as consensual themes, has allowed for the preserving of nuances.

#### 6) Accomplishing general versus specific research tasks

This concerns the appropriateness of the method for addressing the research questions, and the necessity for a realistic appraisal of the generalisability of the findings.

Concerning appropriateness, it has already been argued in the 'Introduction' chapter that a content analytic approach, underpinned by social representations theory, is an appropriate method for investigating the public's views on psychology and psychologists. However, although this method results in richer data than quantitative self-report approaches, it is still subject to social desirability effects. As the discursive critique has already pointed out, this method does not take into account the way the data may have been shaped by the politics of the research situation. This method also does not

allow for much interpretation as to the way in which language was used, such as inferences from intonation. Furthermore, participants varied in the extent to which they were able to articulate their ideas, and the relatively unstructured nature of the interviews meant that relevant ideas may have gone unmentioned.

Concerning generalisability, the in-depth nature of the study necessitated the use of a relatively small sample size, which can limit generalisability. One way to minimise this problem is to try to ensure the sample is as representative of the population as possible. In the present study, considerable effort went into addressing this issue of representativeness, in order to maximise possible generalisability. Representativeness was addressed by recruiting participants from a variety of locations in north, south, east and west London. However, all of these were types of social club, and it is unclear to what extent the results can be generalised to people who do not attend such places or who live outside London. Furthermore, it is questionable to what extent the results can be generalised to different demographic groups, particularly as social representations theory would argue that ethnicity, age, education, occupational history and choice of newspaper would all be factors which affect people's social representations.

However, having considered the limitations of generalising from the present sample, given the attention to representativeness, it seems reasonable to suggest that the findings could be generalisable to other white British London-based tabloid readers within the two age groups.

### 7) *Resonating with readers*

This concerns the need for the researcher to aim at clarifying and expanding the reader's appreciation and understanding of the subject matter. The 'Discussion' chapter has been written with this final criterion in mind.

## **SUGGESTIONS FOR FUTURE RESEARCH**

Five avenues for future research are suggested by the present study. Firstly, whilst social representations theory incorporates the notions of 'anchoring' and 'objectification' as key processes in the formation of social representations, this study has focused primarily on how participants anchored ideas about psychology. Little has been said regarding objectification. In the context of this study, this refers to the kinds of symbols and metaphors used within the sample to concretise and convey concepts related to psychology, such as the metaphor of the human mind as a machine which can therefore break down. An exploration of the symbols apparent in the data from this study could enrich understanding of the social representations of the sample.

Secondly, social representations are presumed to be carried within a variety of modes and mediums. The former have been distinguished as habitual behaviour, individual cognition, informal communication, and formal communication, e.g. mass media, and the latter as movement, words, visual images and non-linguistic sounds (Bauer & Gaskell, 1999). The present study focused on the modes of individual cognition and informal communication and the medium of words. Further research could explore the social representations of psychology inherent in different modes and mediums, and the extent to which the findings concur with those of the present study.

In line with the work on images of madness (D.Rose, 1996; Rose, 1998) one suggestion is the investigation of visual images associated with psychology in films and magazines in the UK, particularly as some recent portrayals seem to present providers of psychological help as somewhat eccentric, e.g. television dramas such as 'Ally McBeal' and 'Psychos'. This would perhaps fit with the findings of the present study, in which some of the participants viewed psychologists as weird in some way.

This triangulation of different data sources from different modes and mediums enables multiple perspectives to be captured (Flick, 1992; Smith, 1996). This would thereby facilitate greater understanding of core, peripheral and paradoxical elements of representations of psychology (Bauer & Gaskell, 1999). Mirroring recent trends in the larger psychological community (Barker et al, 1994; Burt & Oaksford, 1999), social representations research has embraced a spectrum of methodologies (Wagner et al, 1999). Building on the present study, then, understanding of public social representations of psychology could be enriched by using questionnaires, rating scales, word association tasks and group discussions to capture different levels of awareness of participants (Markova, 1996). Furthermore, more discursive methodologies could be used to investigate the function of social representations of psychology in different research contexts. However, as in all domains of social science research, a methodologically eclectic approach needs to give adequate consideration to potential underlying epistemological incompatibilities (Hammersley, 1996).

A third avenue for future research suggested by the present study would be to investigate the replicability of the findings, and which aspects, if any, generalise to samples of the public who differ demographically, for example in terms of ethnicity, age,



education, geographical location or choice of newspaper. Social representations theory proposes that social representations are shaped by group identity (Bauer & Gaskell, 1999; Joffe, 1996b; Wagner et al, 1999), so further work on the social representations of psychology in different groups would inform clinical psychologists as to how best to interact with different groups. However, if such work suggested substantial consensus across groups, this would point to the possibility of a more fundamental universal set of representations of psychology. The results of questionnaire studies from other cultures, such as Australia (Hopson & Cunningham, 1995), Norway (Hamre, Dahl & Malt, 1994), South Africa (Stones, 1996) and the US (Tinsley et al, 1984), suggest that this possibility may have some validity, as does the internationally consistent finding that only a low percentage of people with psychological difficulties would consider seeking professional help (Barker et al, 1990; Bland et al, 1997; Hoeger, 1995; Madianos et al, 1993; Rickwood & Braithwaite, 1994; Savaya, 1998; Veroff et al, 1981).

The fourth direction for future research suggested by the present study is to investigate the social representations of psychology in groups other than the general public, and to compare the findings with those from the present study. One possible example is to compare the results of the present study with psychologists' ideas as to what social representations they would have expected the public to hold, because this has implications for the way in which practitioners interact with clients.

Studies of the social representations of psychology in other groups which could have important clinical implications include :-

- existing clients of psychologists (cf Pistrang & Barker, 1992)

- people who do not attend for their appointments with psychological services versus those who do (cf Morton, 1995)
- people on the waiting list for psychological therapy versus those who have completed therapy
- people before and after they have been through therapy
- close family or friends of people who are clients of psychologists

The fifth, and final, area for future research suggested by the present study would be to investigate the social representations amongst the public of other psychological help providers or mental health professionals, such as psychiatrists, counsellors or psychiatric nurses, and to compare these to the results of the present study (cf Tinsley et al, 1984). It would also be interesting to find out to what extent participants' social representations differed if the terms 'clinical psychology/psychologist' were used rather than the more generic terms 'psychology/psychologist' which were used in the present study. The pilot study for the present research suggested that participants found the terms 'clinical psychology/psychologists' more bewildering and threatening. This begs the question as to how the public construe the term 'clinical', and, if substantiated, has potential clinical implications.

### **CLINICAL IMPLICATIONS**

Some interesting clinical implications emerge from the findings of the present study, despite its limitations. The main message appears to be that people who have no direct experience of psychological services nevertheless imbue them with a plethora of socio-culturally inherited ideas (Pilgrim, Rogers, Clarke & Clark, 1997), and therefore

seem to be carrying complex social representations of psychology and psychologists. It is useful for clinical psychologists to know about these representations because they are likely to underpin public opinions about psychology. Furthermore, although the representations held by potential clients who present for services may differ from those of this sample, there is evidence that the beliefs of non-clients may shape clients' beliefs (Deane & Todd, 1996). As clients beliefs are known to impact upon the course of therapy (Clinton, 1996; Faller, 1998; Joyce & Piper, 1998; Ross et al, 1994), this highlights the importance of clinical psychologists knowing about social representational issues, as these may underpin encounters with individual clients (Harris, 1994), as well as with the public at large.

In terms of potential clients, an understanding of the possible social representations of psychology needs to be incorporated into how clinical psychologists work with clients. The issue of adequate 'socialisation' of people into how to be a client was being discussed in the literature in the US over 30 years ago (Orme & Wender, 1968). Many of the points made then seem to be at least partly relevant to the present UK sample, such as the lack of universal awareness as to the differences between a medical and a psychological consultation, and between the style of medical and psychological treatments. As these authors point out, there is a difference between someone for whom psychological intervention is unsuitable and someone who just does not know what to expect, and so they argue for the benefits of a pre-therapy socialisation interview to ensure treatment adherence. Although this might constitute a luxury in today's resource-conscious NHS, nevertheless clinical psychologists have an ethical obligation to obtain informed consent to treatment from potential clients (British Psychological Society

Division of Clinical Psychology Professional Practice Guidelines, 1995). The findings from the present study highlight the importance of ensuring adequate socialisation on first meeting a potential client, so that clients are empowered to make genuinely informed decisions about their care.

However, a review of the literature on methods of socialisation concluded that verbal and printed material were largely ineffective in altering client expectancies regarding psychological treatment (Tinsley, Bowman & Ray, 1988). Audiotaped and videotaped materials seem to be more effective (Deane, Spicer & Leathem, 1992; Tinsley et al, 1988). The studies using audio and video material generally seemed to be more interactive than those using verbal or printed material. One possible conclusion from this is that socialisation by itself may be inadequate in addressing the underlying meaning of becoming a client, which, it is argued, is driven by the kinds of social representations illuminated in this study. If socialisation is conceptualised and conducted as a unidirectional and purely intellectual process from psychologist to client, there is little opportunity for the underlying emotions, presumed to be driven by social representations, to be aired and re-shaped. The present study has suggested how crucial these underlying emotions may be in influencing people's response to psychology.

One important clinical implication of the present study, then, seems to be that, whilst some degree of socialisation would seem to be necessary ethically, clinical psychologists should not underestimate the need for an interactive dialogue with potential clients, exploring what it means to them to be there, and their expectancies regarding how matters will proceed. The explicit inclusion of emotive topics, such as stigma-related issues, may help to set the potential client more at their ease (Esters, Cooker & Ittenbach,

1998), thereby reducing the likelihood of attrition (Deane & Todd, 1996) and facilitating the development of a useful working alliance. It is argued that this kind of approach, if conducted with sensitivity, is more likely to have a useful impact on the person's beliefs and behaviour, because it addresses underlying concerns at a more emotional level (Joffe, 1996b & 1999; Markova, 1996).

Some models of therapy explicitly incorporate these kinds of ideas. Contemporary systemic therapists have argued for the need to address at referral, and throughout therapy, people's 'relationship to help' and the beliefs that contribute to it (Reder & Fredman, 1996). Similarly, cognitive behaviour therapists have highlighted the need to be aware of and address the broad range of possible factors, both individual and socio-cultural, that may affect the therapeutic alliance, and thus the course of therapy (Wright & Davis, 1994).

The present study, in its exploration of current social representations of psychology, suggests that there are a number of issues that should be raised and discussed in the early stages of engaging with a client, regardless of therapeutic orientation. One possible way in which to do this would be to provide potential clients with an introductory information sheet covering the relevant issues, which is then discussed at the first meeting. A possible example is provided in Appendix VII. This preliminary draft example aims to cover the main findings of the present study in such a way as to correct likely misperceptions, and to re-frame the therapeutic endeavour in a positive light. This would therefore socialise people regarding the nature of psychological treatment, begin to address the more negative elements of people's social representations, and provide a starting point for an interactive dialogue about these issues at the first session.

This leads to the suggestion that applied research using the introductory information sheet for potential clients presented in draft form in Appendix VII provides a sixth possible avenue for future research, in addition to the five outlined earlier. It would be interesting to investigate to what extent the use of such a document might impact upon attendance, outcome and client satisfaction.

Applied research based on use of the document in Appendix VII could be conducted across a service as a whole. Alternatively, different versions of the document could be produced for different types of client. The findings from the present study enable some suggestions to be made as to how and what material should be presented in this way, depending on the intended recipient.

In order to cater for male clients, the findings here suggest the importance of emphasising the positive re-framing of help-seeking as a proactive and courageous act. This is so that it may perhaps be viewed as less threatening to the male gender identity (Good & Wood, 1995).

It is also suggested that, for men and older clients in particular, the role of external factors in contributing to psychological distress needs to be accentuated. This is because their greater propensity for making internal attributions is likely to result in negative self-appraisal for help-seeking, which may impact upon the course of therapy or cause premature termination (Kunkel & Williams, 1991).

Additionally, it is suggested that older clients may need more emphasis on the collaborative nature of therapy, to counteract their greater tendency to view psychologists as the active experts and themselves as passive recipients of treatment.

The suggestions so far concern the ways in which individual psychology services may deal with individual clients. From a social representational perspective, clinical psychology as a profession needs to consider how it can attempt to catalyse a positive shift in social representations across the public at large (Deane & Todd, 1996; Harris, 1994). Without such a systemic shift, the issues at the level of the individual will continue to occur, because the same types of social representation will continue to circulate.

Clinical psychologists, in their role as society's experts, are collectively in a position to influence future social representations of psychology and of psychological distress by the ideas that they choose to disseminate to the public (Hopson & Cunningham, 1995; Morant, 1998). In order to achieve an impact which is positive for clients, for potential clients and for the profession, it is argued that clinical psychology needs to discuss, openly and publicly, the more emotive aspects of current social representations.

A Kleinian rationale for this is that raising such issues to a more conscious awareness would facilitate change, enabling an increasing incorporation of the 'depressive position' into mainstream social representations (Joffe, 1996b).

In more sociological terms, the public production of explanations and commentaries by society's experts enhances reflexivity, and hence the revision of ideas inherited from a less reflexive past (Giddens, 1991). The results of the present study give some indications that this kind of shift is already underway, at least in some sections of society, perhaps as a result of the impact of 'pop psychology' (Harris, 1994). It is the

responsibility of clinical psychologists, as society's experts, to work towards further accelerating this shift.

## **CONCLUSIONS**

The findings of the present study can be understood in terms of two of the processes incorporated in social representations theory. These two processes are anchoring and dissemination of ideas from expert circles to the public domain.

Firstly, ideas about psychology appeared to be clearly anchored to socio-historical ideas about 'madness'. This means that although psychology per se is a relatively new, and therefore unfamiliar, concept, the public seem to have rendered it familiar by anchoring it to inherited socio-cultural ideas, such as the view of psychological distress as a medical condition of the mind, qualitatively distinct from physical distress, which threatens an individual's sense of authentic personhood, and is therefore to be avoided and stigmatised (Gilman, 1988; deRosa, 1987; D.Rose, 1996; Turner, 1986).

Secondly, several aspects of the social representations that emerged appear to be the result of the dissemination of two sets of expert ideas. The first set of expert ideas concerns the confusion and difficulty mental health professionals have in trying to conceptualise psychological problems and the nature of their work with clients (Morant, 1998). This collective uncertainty and mixing of multiple models appears to have diffused into the public domain, as it is apparent in the social representations of the present sample. Also apparent was the conflict between the traditional psychiatric view of the discontinuity of mental illness and mental health, which proposes a qualitative distinction between them, and the more psychological view of mental health as being on



a continuum, with mental distress being viewed as merely quantitatively different (Pilgrim & Treacher, 1992).

The second set of expert ideas which appear to have diffused into the public arena concern clinical psychology more specifically, and relate to the public's view, found overwhelmingly in the present study, of clinical psychology as a medical discipline.

The discipline of clinical psychology emerged originally from psychiatry, and, from the outset, psychiatry attempted to retain dominance over psychological domains, for example by declaring early in the development of psychotherapy that it was a medical procedure (Pilgrim & Treacher, 1992). Meanwhile, clinical psychology struggled to gain professional independence from the medical establishment. However, concurrent with this struggle was a wish for the status enjoyed by medical colleagues. Indeed, Pilgrim (2000) has argued that even today there are times when clinical psychologists selectively adhere to a medical knowledge base in order to boost their public image and status.

This continued ambivalence towards the dominant medical culture, combined with the development and evolution of multiple models of psychological distress, gives a sense of the roots of what has been described as the profession's identity crisis (Pilgrim & Treacher, 1992).

The issue of defining clinical psychology is still a topic for debate within professional circles (Harvey, 1999). Moreover, this contemporary and historical professional confusion appears to have been transmitted to the public, in that the participants in the present study seemed to hold social representations of psychologists as medical experts who use non-medical treatments to deal with problems construed in a

variety of at least partly non-medical ways, and who are additionally anchored to non-professional helpers.

In terms of future social representations of psychology, it seems unlikely that psychic collapse, which offers such a fundamental threat to Western ideals of authentic personhood (Turner, 1986), could ever be viewed as anything but a fearful prospect. However, if the expansion of the 'pop psychology' culture continues, its positive stance towards self-discovery could result in an increase in social representations of psychology as a positive and proactive way for people to address distress.

The increased 'psychologising' of society means that psychologists are now viewed as one of society's expert groups (N.Rose, 1996). In particular, the recent growth of interest in clinical psychology is unprecedented (Roth, 1998). Clinical psychologists have therefore never been in a stronger position to promote a societal re-framing of psychological help as a useful coping strategy for the distress which is so often a part of the experience of being human, rather than as a shameful admission of personal inadequacy. Striving towards such a re-frame could shift social representations in a direction which would have positive consequences both for clients and for clinical psychology as a profession. Clients could increasingly be viewed more as people who are working to expand their coping repertoire, rather than as failures or 'nutters', and clinical psychologists could be viewed as facilitating this process, rather than as the custodians of failure or 'madness'.

Psychology is relatively new as an independent discipline, but it has emerged from a long tradition of thought in both philosophy and science (Hall & Marzillier, 1992). This observation has led to the idea that psychology has a short history but a long past.

The present study seems to suggest that this is also true of clinical psychology. The profession of clinical psychology was born as recently as the 1950s (Pilgrim & Treacher, 1992), yet the results from this study suggest that, in the eyes of the public, it is firmly rooted in the long tradition of ideas about mental health and 'madness'. In the final analysis, it is suggested that clinical psychologists should never lose sight of this if they wish to promote greater understanding and acceptance for their clients amongst the public, and to enhance effectiveness of NHS psychological services in the new millennium.

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## **REFERENCES**

- Antaki, C. (2000). Why I study talk-in-interaction. The Psychologist, 13(5), 242-243.
- Arkowitz, H. (1997). Integrative theories of therapy. In Wachtel, P. & Messer, S.B. (Eds.) Theories of Psychotherapy: Origins and Evolution. Washington, DC: American Psychological Association.
- Banyard, P. & Hunt, N. (2000). Reporting research: something missing? The Psychologist, 13(2), 68-71.
- Barbour, R.J. (1998). Mixing qualitative methods: quality assurance or qualitative quagmire. Qualitative Health Research, 8, 362-376.
- Barker, C., Pistrang, N. & Elliott, R. (1994). Research Methods in Clinical and Counselling Psychology. Chichester: John Wiley & Sons.
- Barker, C., Pistrang, N., Shapiro, D.A. & Shaw, I. (1990). Coping and help-seeking in the UK adult population. British Journal of Clinical Psychology, 29, 271-285.
- Bauer, M.W. & Gaskell, G. (1999). Towards a paradigm for research on social representations. Journal for the Theory of Social Behaviour, 29(2), 163-186.

Berelson, B. (1952). Content Analysis in Communication Research. Illinois: Glencoe Free Press.

Bland, R.C., Newman, S.C. & Orn, H. (1997). Help-seeking for psychiatric disorders. Canadian Journal of Psychiatry, 42(9), 935-942.

Brewin, C. & Furnham, A. (1986). Attributional versus pre-attributional variables in self-esteem and depression. Journal of Personality and Social Psychology, 50, 1013-1020.

British Psychological Society Division of Clinical Psychology (1995). Professional Practice Guidelines. Leicester: British Psychological Society.

Burt, K. & Oaksford, M. (1999). Qualitative methods: beyond beliefs and desires. The Psychologist, 12(7), 332-335.

Carpenter, P.J., Morrow, G.R., Del Gaudio, A.C. & Ritzler, B.A. (1981). Who keeps the first outpatient appointment? American Journal of Psychiatry, 138(1), 102-105.

Cepeda-Benito. A. & Short, P. (1998). Self-concealment, avoidance of psychological services and perceived likelihood of seeking professional help. Journal of Counselling Psychology, 45(1), 58-64.

Clinton, D.N. (1996). Why do eating disorder patients drop out? Psychotherapy and Psychosomatics, 65(1), 29-35.

Deane, F.P. & Chamberlain, K. (1994). Treatment fearfulness and distress as predictors of professional psychological help-seeking. British Journal of Guidance and Counselling, 22, 207-217.

Deane, F.P., Spicer, J. & Leathem, J. (1992). Effects of videotaped preparatory information on expectations, anxiety and psychotherapy outcome. Journal of Consulting and Clinical Psychology, 60, 980-984.

Deane, F.P. & Todd, D.M. (1996). Attitudes and intentions to seek professional psychological help for personal problems or suicidal thinking. Journal of College Student Psychotherapy, 10(4), 45-59.

DeBarbot, F.M. (1977). A cross-cultural study of attitudes towards seeking professional help. Dissertation Abstracts International, Series B, 38, 1875.

DeRosa, A.M. (1987). The social representations of mental illness in children and adults. In Doise, W. & Moscovici, S. (Eds.). Current Issues in European Social Psychology. Cambridge: Cambridge University Press.

Diesling, P. (1981). Patterns of discovery in the social sciences. In Reason, P. & Rowan, J. (Eds.) Human Enquiry. Chichester: Wiley.

Eagly, A.H., Mladinic, A. & Otto, S. (1994). Cognitive and affective bases of attitudes toward social groups and social policies. Journal of Experimental Social Psychology, 30, 113-137.

Elliott, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. British Journal of Clinical Psychology, 38(3), 215-229.

Esters, I.G., Cooker, P.G. & Ittenbach, R.F. (1998). Effects of a unit of instruction in mental health on rural adolescents' conceptions of mental illness and attitudes about seeking help. Adolescence, 33(130), 469-476.

Faller, H. (1998). Treatment expectations in psychotherapy patients. Psychotherapeut, 43(1), 8-17.

Fischer, E.H. & Turner, J.L. (1970). Orientations to seeking professional help: development and research utility of an attitude scale. Journal of Consulting and Clinical Psychology, 35(1), 79-90.

Fischer, A.R., Jome, L.M. & Atkinson, D.R. (1998). Back to the future of multicultural psychotherapy with a common factors approach. Counseling Psychologist, 26(4), 602-606.

Fisher, J.D. & Farina, A. (1979). Consequences of beliefs about the nature of mental disorders. Journal of Abnormal Psychology, 88, 320-327.

Flick, U. (1992). Triangulation revisited: strategy of validation or alternative? Journal for the Theory of Social Behaviour, 22(2), 175-197.

Furnham, A. (1985). Just world beliefs in an unjust society: a cross-cultural comparison. European Journal of Social Psychology, 15, 363-366.

Furnham, A. (1993). A comparison between psychology and non-psychology students' misperceptions of the subject. Journal of Social Behavior and Personality, 8(2), 311-322.

Furnham, A. (1997). Overcoming neuroses: lay attributions of cure for five specific neurotic disorders. Journal of Clinical Psychology, 53(6), 595-604.

Furnham, A. & Hayward, R. (1997). A study and meta-analysis of lay attributions of cures for overcoming specific psychological problems. Journal of Genetic Psychology, 158(3), 315-331.



Furnham, A. & Henley, S. (1988). Lay beliefs about overcoming psychological problems. Journal of Social and Clinical Psychology, 6(3/4), 423-438.

Furnham, A. & Rawles, R. (1993). What do prospective psychology students know about the subject? Psychologia: An International Journal of Psychology in the Orient, 36(4), 241-249.

Furnham, A. & Rees, J. (1988). Lay theories of schizophrenia. International Journal of Social Psychiatry, 34, 212-220.

Furnham, A. & Wardley, Z. (1990). Lay theories of psychotherapy I: Attitudes to, and beliefs about, psychotherapy and psychotherapists. Journal of Clinical Psychology, 46, 878-890.

Furnham, A. & Wardley, Z. (1991). Lay theories of psychotherapy II: The efficacy of different therapies and prognosis for different problems. Human Relations, 44(11), 1197-1211.

Furnham, A., Wardley, Z. & Lillie, F. (1992). Lay theories of psychotherapy III: Comparing the ratings of lay persons and clinical psychologists. Human Relations, 45(8), 839-858.

Gahan, C. & Hannibal, M. (1998). Doing Qualitative Research Using QSR NUD\*IST. London, California, New Delhi: Sage.

Garfield, S.L. (1986). Research on client variables in psychotherapy. In Garfield, S.L. & Bergin, A.E. (Eds.) Handbook of Psychotherapy and Behavior Change. San Francisco: Jossey-Bass.

Geer, J.G. (1991). Do open-ended questions measure 'salient' issues? Public Opinion Quarterly, 55, 360-370.

Gergen, K. (1999). An Invitation to Social Constructionism. London: Sage.

Giddens, A. (1991). Modernity and Self-identity. Cambridge: Polity Press.

Gilman, S.L. (1988). Disease and Representation: Images of Illness from Madness to AIDS. Ithaca: Cornell University Press.

Gill, R. (1996). Discourse analysis: practical implementation. In Richardson, J. (Ed.) Handbook of Qualitative Research Methods for Psychology and the Social Sciences. Leicester: British Psychological Society.

Goldner, V., Penn, P., Sheinberg, M. & Walker, G. (1990). Love and violence: gender paradoxes in volatile attachments. Family Process, 29(4), 343-364.

Goldstein, A. (1962). Therapist-Patient Expectancies in Psychotherapy. New York: MacMillan.

Good, G.E. & Wood, P.K. (1995). Male gender role conflict, depression, and help seeking: do college men face double jeopardy? Journal of Counseling and Development, 74, 70-75.

Haddock, G. & Zanna, M.P. (1998). On the use of open-ended measures to assess attitudinal components. British Journal of Social Psychology, 37, 129-149.

Hall, J. & Marzillier, J. (1992). What is clinical psychology? In Marzillier, J. & Hall, J. (Eds.) What is Clinical Psychology? Oxford: Oxford University Press.

Hammersley, M. (1996). The relationship between qualitative and quantitative research: paradigm loyalty versus methodological eclecticism. In Richardson, J. (Ed.) Handbook of Qualitative Research Methods for Psychology and the Social Sciences. Leicester: British Psychological Society.

Hamre, P., Dahl, A.A. & Malt, U.F. (1994). Public attitudes to the quality of psychiatric treatment, psychiatric patients, and the prevalence of mental disorders. Nordic Journal of Psychiatry, 48(4), 275-281.

Harris, M.J. (1994). Self-fulfilling prophecies in the clinical context: review and implications for clinical practice. Applied & Preventive Psychology, 3, 145-158.

Harvey, P. (1999). Division news: from your Chair. Clinical Psychology Forum, 130, 50.

Heilbrun, A. (1970). Towards a resolution of the dependency-premature termination paradox for females in psychotherapy. Journal of Consulting and Clinical Psychology, 34, 382-386.

Henley, S. & Furnham, A. (1988). The attribution of cure. British Journal of Clinical Psychology, 27, 384-386.

Henriques, J., Hollway, W., Urwin, C., Venn, C. & Walkerdine, V. (1998). Changing The Subject: Psychology, Social Regulation and Subjectivity. London: Routledge.

Henwood, K.L. (1996). Qualitative inquiry: perspectives, methods and psychology. In Richardson, J. (Ed.) Handbook of Qualitative Research Methods for Psychology and the Social Sciences. Leicester: British Psychological Society.

Hewstone, M. (1983). Attribution Theory: Social and Functional Extensions. Oxford: Blackwell.

Hoeger, C. (1995). Who enters treatment? Influences on service utilization patterns of children and adolescents with psychological problems. Praxis der Kinderpsychologie und Kinderpsychiatrie, 44(1), 3-8.

Hollway, W. & Jefferson, T. (1997). Eliciting narrative through the in-depth interview. Qualitative Enquiry, 3(1), 53-70.

Holsti, O.R. (1969). Content analysis. In Lindzey, G. & Aronson, E. (Eds.) Handbook of Social Psychology. Reading, Massachusetts: Addison-Wesley.

Hopson, K. & Cunningham, J.D. (1995). Community and client perceptions of psychologists and other health professionals. Australian Psychologist, 30(3), 213-217.

Jodelet, D. (1991). Madness and Social Representations: Living with the Mad in One French Community. Translated by Pownall, T. California: University of California Press.

Joffe, H. (1996a). AIDS research and prevention: A social representational approach. British Journal of Medical Psychology, 69, 169-190.

Joffe, H. (1996b). The shock of the new: a psycho-dynamic extension of social representational theory. Journal for the Theory of Social Behaviour, 26(2), 197-219.

Joffe, H. (1999). Risk and 'The Other'. Cambridge: Cambridge University Press.

Jovchelovitch, S. (1996). In defence of representations. Journal for the Theory of Social Behaviour, 26(2), 122-135.

Joyce, A.S. & Piper, W.E. (1998). Expectancy, the therapeutic alliance and treatment outcome in short-term individual psychotherapy. Journal of Psychotherapy Practice and Research, 7(3), 236-248.

King, E. (1996). The use of the self in qualitative research. In Richardson, J. (Ed.) Handbook of Qualitative Research Methods for Psychology and the Social Sciences. Leicester: British Psychological Society.

Klein, M. (1952). Some theoretical conclusions regarding the emotional life of the infant. In Klein, M., Hemann, P., Isaacs, S. & Riviere, J. (Eds.) Developments in Psychoanalysis. London: Hogarth Press.

Krippendorff, K. (1980). Content Analysis: An Introduction to its Methodology. London: Sage.

Kunkel, M.A. & Williams, C. (1991). Age and expectations about counselling: two methodological perspectives. Journal of Counselling & Development, 70, 314- 321.

Kushner, M.G. & Sher, K.J. (1989). Fear of psychological services and its relation to service utilization. Professional Psychology: Research and Practice, 20, 251-257.

Kushner, M.G. & Sher, K.J. (1991). The relation of treatment fearfulness and psychological service utilization: an overview. Professional Psychology: Research and Practice, 22(3), 196-203.

Leaf, P.J., Livingston, M.M., Tischler, G.L., Weissman, M.M., Holzer, C.E. & Myers, J.K. (1985). Contact with health professionals for treatment of mental or emotional problems. Medical Care, 23, 1322-1337.

Leaf, P.J., Bruce, M.L., Tischler, G.L. & Holzer, C.E. (1987). The relationship between demographic factors and attitudes toward mental health services. Journal of Community Psychology, 15, 275-284.

Leong, F.T.L. & Zachar, P. (1999). Gender and opinions about mental illness as predictors of attitudes toward seeking professional psychological help. British Journal of Guidance and Counselling, 27(1), 123-132.

Llewelyn, S. (1988). Psychological therapy as viewed by clients and therapists. British Journal of Clinical Psychology, 27, 223-237.

Lorenzi-Cioldi, F. (1996). Psychological androgyny: a concept in search of lesser substance. Journal for the Theory of Social Behaviour, 26(2), 137-155.

Luk, C.L. & Bond, M. (1992). Chinese lay beliefs about the causes and cures of psychological problems. Journal of Social and Clinical Psychology, 11, 140-157.

Madianos, M.G., Madianou, G.D. & Stefanis, C.N. (1993). Help-seeking behaviour for psychiatric disorder from physicians or psychiatrists in Greece. Social Psychiatry and Psychiatric Epidemiology, 28(6), 285-291.

Marzillier, J. & Hall, J. (1992). Overview and implications. In Marzillier, J. & Hall, J. (Eds.) What is Clinical Psychology? Oxford: Oxford University Press.

Markova, I. (1996). Towards an epistemology of social representation. Journal for the Theory of Social Behaviour, 26(2), 177-196.

Matschinger, H. & Angermeyer, M.C. (1996). Lay beliefs about the causes of mental disorders: a new methodological approach. Social Psychiatry and Psychiatric Epidemiology, 31, 309-315.

Modcrin, M.J. & Wyers, N.L. (1990). Lesbian and gay couples: where they turn when help is needed. Journal of Gay and Lesbian Psychotherapy, 1, 89-104.



Morrison, D.P. (1991). Integrating consumerism into clinical care delivery: the role of the therapist. Administration and Policy in Mental Health, 19(2), 103-119.

Morton, A. (1995). The enigma of non-attendance: a study of clients who do not turn up for their first appointment. Therapeutic Communities, 16(2), 117-133.

Moscovici, S. (1976). La Psychanalyse: Son Image et Son Public. Paris: Press Universitaires de France (2<sup>nd</sup> edition).

Moscovici, S. (1984). The phenomenon of social representations. In Farr, R.M. & Moscovici, S. (Eds.) Social Representations. Cambridge: Cambridge University Press.

Orme, D.R. & Boswell, D. (1991). The pre-intake drop out at a community mental health centre. Community Mental Health Journal, 27(5), 375-379.

Orme, M.T. & Wender, P.H. (1968). Anticipatory socialization for psychotherapy: method and rationale. American Journal of Psychiatry, 124(9), 1203-1212.

Osborne-Davies, I. (1996). Awareness and attitudes of other health-care professionals towards clinical psychologists. Clinical Psychology Forum, 91, 10-15.

Petty, R.E. & Krosnik, J.A. (1995). Attitude Strength: Antecedents and Consequences. Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Pilgrim, D. (2000). Psychiatric diagnosis: more questions than answers. The Psychologist, 13(6), 302-305.

Pilgrim, D., Rogers, A., Clarke, S. & Clark, W. (1997). Entering psychological treatment: decision-making factors for GPs and service users. Journal of Interprofessional Care, 11(3), 313-324.

Pilgrim, D. & Treacher, A. (1992). Clinical Psychology Observed. London: Routledge.

Pipes, R.B., Schwarz, R. & Crouch, P. (1985). Measuring client fears. Journal of Consulting and Clinical Psychology, 53, 933-934.

Pistrang, N. & Barker, C. (1992). Clients' beliefs about psychological problems. Counselling Psychology Quarterly, 5(4), 325-335.

Potter, J. (1996). Attitudes, social representations and discursive psychology. In Wetherell, M. (Ed.) Identities, Groups and Social Issues. London: Sage.

Purkhardt S.C. (1993). Transforming Social Representations: A Social Psychology of Common Sense and Science. London: Routledge.

Reder, P. & Fredman, G. (1996). The relationship to help: interacting beliefs about the treatment process. Clinical Child Psychology and Psychiatry, 1(3), 457-467.

Rickwood, D.J. & Braithwaite, V.A. (1994). Social psychological factors affecting help-seeking for emotional problems. Social Science and Medicine, 39(4), 563-572.

Roberts, D. & Claridge, G. (1991). A genetic model compatible with a dimensional view of schizophrenia. American Journal of Psychiatry, 158, 451-456.

Rose, D. (1996). Representations of madness on British television: A social psychological analysis. Unpublished PhD thesis.

Rose, N. (1996). Expertise and the 'techne' of psychology. In Rose, N. Inventing Our Selves: Psychology, Power and Personhood. Cambridge: Cambridge University Press.

Ross, C.K., Frommelt, G., Hazelwood, L. & Chang, R.W. (1994). The role of expectations in patient satisfaction with medical care. In Cooper, P.D. (Ed.) Health Care Marketing: A Foundation For Managed Quality (3<sup>rd</sup> edition). Gaithersburg, USA: Aspen Publishers.

Roth, T. (1998). Getting on clinical training courses. The Psychologist, 11 (12), 589-592.

Sandler, W. (1975). Patient-therapist dissimilarity of role expectations related to premature termination of psychotherapy with student therapists. Dissertation Abstracts International, 35, 6111-6112.

Savaya, R. (1998). The under-use of psychological services by Israeli Arabs: an examination of the roles of negative attitudes and the use of alternative sources of help. International Social Work, 41(2), 195-209.

Schneider, I. (1987). The theory and practice of movie psychiatry. American Journal of Psychiatry, 144, 996-1002.

Sibicky, M. & Dovidio, J.F. (1986). Stigma of psychological therapy: stereotypes, interpersonal reactions, and the self-fulfilling prophecy. Journal of Counseling Psychology, 33, 148-154.

Smith, J.A. (1996). Evolving issues for qualitative psychology. In Richardson, J. (Ed.) Handbook of Qualitative Research Methods for Psychology and the Social Sciences. Leicester: British Psychological Society.

Snyder, J., Hill, C. & Derksen, T. (1972). Why some students do not use University Counseling Psychology facilities. Journal of Counseling Psychology, 19, 263-268.

Socall, D.W. & Holtgraves, T. (1992). Attitudes toward the mentally ill: the effects of label and beliefs. The Sociological Quarterly, 33, 435-445.

Steffl, M.E. & Prosperi, D.C. (1985). Barriers to mental health service utilization. Community Mental Health Journal, 21, 167-178.

Stones, C.R. (1996). Attitudes toward psychology, psychiatry and mental illness in the central eastern Cape of South Africa. South African Journal of Psychology, 26(4), 221-225.

Stricker, G. (1994). Reflections on psychotherapy integration. Clinical Psychology: Science and Practice, 1(1), 3-12.

Tinsley, H.E.A., Bowman, S.L. & Ray, S.B. (1988). Manipulation of expectancies about counseling and psychotherapy: review and analysis of expectancy manipulation strategies and results. Journal of Counseling Psychology, 35(1), 99-108.

Tinsley, H.E.A., Brown, M.T., de St. Aubin, T.M. & Lucek, J. (1984). Relation between expectancies for a helping relationship and tendency to seek help from a campus help provider. Journal of Counseling Psychology, 31, 149-160.

Tinsley, H.E.A., de St Aubin, T.M. & Brown, M.T. (1982). College students help-seeking preferences. Journal of Counseling Psychology, 29, 523-533.

Tinsley, H.E.A. & Harris, D.J. (1976). Client expectations for counseling. Journal of Counseling Psychology, 23(3), 173-177.

Tinsley, H.E.A., Workman, K.R. & Kass, R.A. (1980). Factor analysis of the domain of client expectancies about counseling. Journal of Counseling Psychology, 27, 561-570.

Todd, J.L. & Shapira, A. (1974). US and British self-disclosure, anxiety, empathy and attitudes to psychotherapy. Journal of Cross-Cultural Psychology, 5, 364-369.

Ussher, J. (1997). Body Talk: The Discursive and Material Regulation of Sexuality, Madness and Reproduction. London: Routledge.

Veroff, J.B., Kulka, R.A. & Douvan, E. (1981). Mental Health In America: Patterns of Help-Seeking 1957-1976. New York: Basic Books.

Wagner, W. (1996). Queries about social representation and construction. Journal for the Theory of Social Behaviour, 26(2), 95-120.

Wagner, W., Duveen, G., Farr, R., Jovchelovitch, S., Lorenzi-Cioldi, F., Markova, I. & Rose, D. (1999). Theory and method of social representations. Asian Journal of Social Psychology, 2, 95-125.

Wahl, O.F. (1995). Media Madness: Public Images of Mental Illness. New Brunswick: Rutgers University Press.

Walborn, F.S. (1996). Process Variables: Four Common Elements Of Counseling And Psychotherapy. Pacific Grove, California, USA: Brooks/Cole Publishing.

Warren, M.A. (1982). Is androgyny the answer to sexual stereotyping? In Wetterling-Bragin, M. (Ed.) 'Femininity', 'Masculinity', and 'Androgyny'. Totowa: Littlefield, Adams & Co.

Wicker, A.W. (1971). Attitudes versus actions: the relationship of overt and behavioural responses to attitude objects. In Thomas, K. (Ed.) Attitudes and Behaviour. Harmondsworth: Penguin Books.

Wills, T.A. & DePaulo, B.M. (1991). Interpersonal analysis of the help-seeking process. In Snyder, C.R. & Forsyth, D.R. (Eds.) Handbook of Social and Clinical Psychology: A Health Perspective. New York: Pergamon.

Wong, J.L. (1994). Lay theories of psychotherapy and perceptions of therapists: a replication and extension of Furnham & Wardley. Journal of Clinical Psychology, 50(4), 624-632.

Woolgar, S. (1996). Psychology, qualitative methods and the ideas of science. In Richardson, J. (Ed.) Handbook of Qualitative Research Methods for Psychology and the Social Sciences. Leicester: British Psychological Society.

Wright, J.H. & Davis, D. (1994). The therapeutic relationship in cognitive-behavioral therapy: patient perceptions and therapist responses. Cognitive and Behavioral Practice, 1, 25-45.

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology and Health, 15, 215-228.

Young, I. (1984). Is male gender identity the cause of male domination? In Treblicot, J. (Ed.) Mothering: Essays in Feminist Theory. Totowa, New Jersey: Rowman and Allanheld.



## **APPENDIX I**

**Letter giving ethics committee approval for the study**



The University College London Hospitals

**The Joint UCL/UCLH Committees on the Ethics of Human Research**

Committee A Chairman: Dr F D Thompson

**Please address all correspondence to:**  
Mrs Iwona Nowicka  
Research & Development Directorate  
9th Floor, St Martin's House  
140 Tottenham Court Road, LONDON W1P 9LN  
Tel. 0171- 380 9579 Fax 0171-380 9937  
e-mail: i.nowicka@academic.uclh.nthames.nhs.uk

Ms F Johnston  
Doctoral Student/Clinical Psychologist in Training

March 10, 1999

Dear Ms Johnston

Study No: 99/0065  
Title: **Public views about clinical psychology and clinical psychologists: A social representational approach.**

We have reviewed the above application and agreed it by Chairman's Action. You may go ahead with your study.

Please note that it is important that you notify the Committee of any adverse events or changes (name of investigator etc) relating to this project. You should also notify the Committee on completion of the project, or indeed if the project is abandoned. **Please remember to quote the above number in any correspondence.**

Yours sincerely

Dr F D Thompson  
Chairman

## **APPENDIX II**

### **Information sheet for participants**



Sub-Department of Clinical Health Psychology

# UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

0181 691 0713

General Enquiries: ~~0171-380 7897~~

~~Clinical Tutor Team: 0171-391-1258~~

~~UCL: 0171-387-7050~~

~~Code from overseas: +44 171-~~

Fax: 0171-916 1989

Dr Helene Joffe, Senior Researcher and Lecturer, University College London  
Fiona Johnston, Clinical Researcher, University College London and Camden & Islington  
Community Health Services NHS Trust

## PUBLIC VIEWS ABOUT PSYCHOLOGY AND PSYCHOLOGISTS

### CONFIDENTIAL INFORMATION FOR PARTICIPANTS

We are inviting you to participate in this study, which aims to investigate how much the general public knows about psychology and psychologists. We hope that the information we obtain will help us in trying to improve the information that is available to the public about these things.

#### **Procedure**

The study can take place at the community centre, in your home or at University College London, whichever you prefer, and takes approximately half an hour. You will be asked some questions concerning what you think and know about psychology and psychologists. Please note, this is not a test in any way. Instead, our aim is to get a true picture of people's genuine opinions and what they do and don't know. Our conversation will be tape-recorded, so that the researchers can listen to it later to get all the important information.

#### **Confidentiality**

Everything you say will be held in confidence and will be used only for research purposes. Your name will not appear on the tape or any notes we take from it. This is so that people feel safe to answer as honestly as possible. We hope to publish the results in scientific journals, but no individual's identity will be revealed.

#### **Ethical approval**

All proposals for research using humans are reviewed by an ethics committee before they are allowed to take place. This proposal has been approved by the Joint University College London / University College London Hospitals Committees on the Ethics of Human Research.

#### **Choosing to take part in the study**

You do not have to take part in this study if you do not want to. If you decide to take part, you may withdraw at any time without having to give a reason.

#### **Further information**

Please feel free to contact Fiona from the research team at any time if you have any questions about the study. She can be reached at the above address or on 0181 691 0713.

*THANK YOU FOR YOUR TIME.*

## **APPENDIX III**

### **Consent form for participants**



Sub-Department of Clinical Health Psychology

# UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

0181 691 0713

General Enquiries: ~~0171-380-7897~~

~~Clinical Tutor Team: 0171-391-1258~~

~~UCL: 0171-387-7050~~

~~Code from overseas: +44 171~~

Fax: 0171-916 1989

Dr Helene Joffe, Senior Researcher and Lecturer, University College London  
Fiona Johnston, Clinical Researcher, University College London and Camden & Islington  
Community Health Services NHS Trust

## PUBLIC VIEWS ABOUT PSYCHOLOGY AND PSYCHOLOGISTS

### INFORMED CONSENT FORM

#### CONFIDENTIAL

Have you read the information sheet about this study? **Yes / No**

Have you had an opportunity to ask questions and discuss this study? **Yes / No**

Have you received satisfactory answers to all your questions? **Yes / No**

Which researcher have you spoken to about this study? .....

Do you understand that you are free to withdraw from this study... **Yes / No**

\* at any time

\* without giving a reason

**Yes / No**

**Yes / No**

Do you agree to take part in this study? **Yes / No**

*Signature:*

*Date:*

*Please print your name:*

*Researcher's signature:*

*Researcher's name:*

## APPENDIX IV

### INTERVIEW SCHEDULE

*Participant number:*

*Date:*

*Age:*

*Sex:*

*Newspaper:*

*Personal contact with a psychologist:*

*Relative/close friend contact:*

*Education:*

*Occupation:*

- 1) When I say the word 'psychologist', tell me what's going through your mind?
- 2) If you heard that someone you knew had seen a psychologist, what would be your reaction?
- 3) What would your reaction be if someone suggested you should go to see a psychologist?
- 4) What do you think psychologists do?
- 5) Do you think they are unique, or are there other people who have a similar function?
- 6) Psychologists often say that when they introduce themselves to people as a psychologist they get an instant reaction from them. What do you think that reaction is about?
- 7) Where do you think your ideas about these things have come from?
- 8) Do you know anyone who has had contact with a psychologist?
- 9) Anything else?

## APPENDIX V

### SAMPLE TRANSCRIPT

*Participant number:* YWN-2

*Date:* 30.7.99

*Age:* 29

*Sex:* Female

*Newspaper:* Sun; Mirror

*Personal contact with a psychologist:* No

*Relative/close friend contact:* No

*Education:* Left school at 16; college at 18

*Occupation:* Child-minding; nanny; nursery working

#### **1) WHEN I SAY THE WORD 'PSYCHOLOGIST', TELL ME WHAT'S GOING THROUGH YOUR MIND?**

Someone that's a sort of cross between a psychiatrist and a counsellor, not quite ... sort of somebody that's like got counselling for some reason but's going to know more about what's going on in your mind than maybe a regular counsellor would. I don't know really [laughs]

*That's fine. You said a cross between a psychiatrist and a counsellor ...*

Well, I don't know ... sort of psychoanalyst ... Somebody that's going to have to know about more ... to find means to cope before its really know what could be the ... I mean you know you can just phone up a doctor and say "I need counselling" and they give you ... and then they would find you a real counsellor wouldn't they, so they're more specialised.

#### **2) IF YOU HEARD THAT SOMEONE YOU KNEW HAD SEEN A PSYCHOLOGIST, WHAT WOULD BE YOUR REACTION?**

Don't know what's going through my head ... what was wrong, if they had problems.

*What's going through your mind about them? What would you think about the situation? What would it mean? What would it say about them?*

Well, no, it wouldn't necessarily say that they're mad or anything. Its not a stigma anymore.



*You say its not a stigma anymore?*

Well there used to be a stigma about seeing anybody that wasn't a regular GP, wasn't there ... about going to see either psychologist, psychiatrist or something like that, or even just a counsellor. He must be completely losing it if he can't cope on his own, stuff like that. I don't think its quite as much as it used to be.

*You said "completely losing it" ...*

Well, you know, not being able to cope like for some people. I mean some people just have problems and cope with them in everyday life and they're OK, but ... more ... Its not quite so much of a taboo as it used to be. You know, there's nobody would admit to going to see anybody.

*And so seeing you mentioned psychologists, psychiatrists, counsellors separate different things ...*

Well ... yeah ... I don't know really. I suppose ... yes, psychiatrist is definitely like a counsellor, and then there's ... Counsellors can be there more just for general things. If you just get a bit fed up with anything and rather than talk ... you can talk about it to somebody and you can't say it, but if not you can speak to a counsellor to get it off your chest. Perhaps that's what it is. I mean I don't know, but perhaps you can just have the option of a psychiatrist.

### **3) *WHAT WOULD YOUR REACTION BE IF SOMEONE SUGGESTED YOU SHOULD GO TO SEE A PSYCHOLOGIST?***

I suppose it depends on the situation. I mean obviously there'd have to be some sort of problem. I'd have to be really upset in some way for someone to suggest that, or have some sort of turmoil.

*And what would you ... how would you feel about ...*

I don't know. I suppose it would be depending ... like I said, it would be depending on how I'm feeling then. It would be hard for me to say that now. If someone said it to me now, I'd think why, cos I'm perfectly all right, perfectly happy. I'm happy with my life, but obviously if I wasn't happy with my life or they see something that was obviously ... I suppose I'd just go visit it, I suppose. That's all I can really say. Its that bit closer than having ... I mean I wouldn't, I definitely wouldn't cancel it.

*And what sort of feelings might you have about the fact that someone had said that? What would it say about you? Would it say anything about you?*

Well it would obviously say that they think that I need help in certain areas of my life. That I maybe couldn't possibly cope with the way things are going at the moment, at that time. And I would have to ... I wouldn't ... It depends ... It probably depends on who said it to me, and in what way it was said. If it was someone that I knew was genuinely a friend, then I'd probably take it better than somebody I thought was trying to be an old whats-it! As I say, you do take things differently from different people. Its like if your mum tells you something, that means ... like say you're going out with a boy. If your mum turns around and says "Ooh I couldn't possibly go out with him! He looks like a tramp!", you'd go out with him just for the hell of it. But if your friend said "Oh no. You're not going out with him!" you'd say "All right then", but you would wouldn't you? [laughs]

*And what would you feel about the one being an interfering old thingy-bobby ... What kind of feelings would that ... ?*

I would be upset. I'd be annoyed. I think initially if someone, I'd tell them to mind their own business and treat them like that, and when I've gone home and think about it, if I think she was right then maybe I'd do something about it, but I probably wouldn't tell her that I'd done it [laughs]

#### **4) WHAT DO YOU THINK PSYCHOLOGISTS DO?**

I suppose they must just ... assess all your beliefs and stability, maybe ... and how you're coping with your problems, how you are, how you cope. Try to find solutions to any problems that you may have practically, rather than just like ... Maybe if they're not taking you seriously, so you end up in a fight. Things like that maybe.

*What they call stability you said ...*

Yes. I think that's where I get confused a bit with psychiatrist. I don't know.

*Can you say a bit more about ...*

Well I suppose, depending on how you come across with how emotional you are and how ... what your actual problem is. That's how they see what you're going to do ... maybe if they think you're going to do something silly, like, I don't know, commit suicide, or something. They've got to assess whether you're OK to live on your own, if you're living on your own, or cope with a family life or having a big trauma, I suppose. A big disaster.

*You mentioned something about confusion between psychiatrist and psychologist ...*

I don't see ... well I don't particularly know ... well there is obviously a difference, but I think. Psychology ... is it more like seeing counsellors or something, but psychiatrists are

sort of ... that's the ones that deal with someone that's schizophrenic or something along those lines, but as I say I'm a bit confused [laughs]

**5) DO YOU THINK THEY ARE UNIQUE, OR ARE THERE OTHER PEOPLE WHO HAVE A SIMILAR FUNCTION?**

I see there's a lap-over, like I was saying before between counsellors and psychologists, but I think ... think they are ... they've got their own jobs to do, I suppose, so probably they're unique.

*How do you think someone would get to be one?*

I suppose college, university ... Maybe you have to be a doctor? ... No, I don't know [laughs]

*That's OK. We want what people's guesses are!*

Yeah, maybe you might have to be a doctor. I haven't really thought about it, to be honest. I suppose you have to get some sort of qualification, but I don't know if you have to be a doctor first or not.

**6) PSYCHOLOGISTS OFTEN SAY THAT WHEN THEY INTRODUCE THEMSELVES TO PEOPLE AS A PSYCHOLOGIST THEY GET AN INSTANT REACTION FROM THEM. WHAT DO YOU THINK THAT REACTION IS ABOUT?**

They're probably wondering if they can read your mind, I would imagine, but other people it's the response if they're fed up about something they're not necessarily going to ... They can tell if you're depressed about something, maybe, just by looking at you. I'm sure you get that.

**7) WHERE DO YOU THINK YOUR IDEAS ABOUT THESE THINGS HAVE COME FROM?**

Could have been through reading, I suppose. Just what you hear from other people.

**8) DO YOU KNOW ANYONE WHO HAS HAD CONTACT WITH A PSYCHOLOGIST?**

No.

*I'm interested that you said that people might think they can read your mind ...*

I think its like ... umm ... if somebody's behaviour's off, they think "Oh God, I bet they can tell I've got roots", and if somebody, I don't know, does nails, or something like that, and comes to analysis you don't show them your hands, if you've bitten your nails down to the stumps, so you ... they're somebody sort of working along them lines, then they must ... They can kind of tell ...

*And what do you think the kind of areas they can tell?*

I don't know ... Say if you've just had a row with your boyfriend and think "I hate him. I'm going to kill you", you think "Oh God. I wonder if they couldn't work out that I said that? I didn't mean it!" it would be that sort of thing, you know.

**9) ANYTHING ELSE?**

No

## **APPENDIX VI**

### **CODING FRAME**

#### **PARENT NODE 1: DISCIPLINE OF PSYCHOLOGY**

**1.1 ANCHORS OF THE DISCIPLINE OF PSYCHOLOGY:** Bodies of knowledge under which psychology is subsumed

- 1.1.1 Medicine – anchoring psychology as a medical discipline
- 1.1.2 Science – anchoring psychology as a scientific discipline
- 1.1.3 Complementary medicine – anchoring psychology to forms of complementary medicine, e.g. hypnosis; reflexology
- 1.1.4 Miscellaneous – anchoring psychology to other disciplines than the above, e.g. self-help/personal growth

**1.2 SUBJECT MATTER OF PSYCHOLOGY:** What psychology is about; what psychologists study; the subject matter of the discipline; the raw material of the discipline. Direct mention of psychology as the study of:

- 1.2.1 The mind (not sufficient to say ‘mental’)
- 1.2.2 Thinking or thought processes
- 1.2.3 Behaviour
- 1.2.4 The brain
- 1.2.5 Feelings or emotions
- 1.2.6 Personality

#### **PARENT NODE 2: NATURE OF THE PROBLEMS PSYCHOLOGY ADDRESSES**

**2.1 TYPE OF PROBLEM:** Labels for the types of problem psychology addresses

##### **2.1.1 Generic labels**

- 2.1.1.1 Mental issues - references to mental illness, mental problems, mental health, mental disorder
- 2.1.1.2 Distress – references to distress, disturbance, upset, emotional difficulties

2.1.1.3 Coping difficulties – references to struggling to cope with, deal with or handle life or problems

## 2.1.2 Specific labels

2.1.2.1 Depressive problems – including depression, bereavement, ‘nervous breakdown’, sadness

2.1.2.2 Antisocial behaviour – including criminality, violence, temper outbursts, general references to ‘antisocial behaviour’

2.1.2.3 Self harm – including suicide, attempted suicide and other forms of self harm, such as self-mutilation

2.1.2.4 Anxiety problems – including worry, stress, pressure and phobias

2.1.2.5 Dementia - including references to dementia, Alzheimer’s disease and senility

2.1.2.6 Relationship issues - including family and marital/partner problems

2.1.2.7 Abuse of children - including abuse by adults, physical or sexual, and abuse by other children, e.g. bullying

2.1.2.8 Addiction - including drugs and alcohol

2.1.2.9 Behavioural problems in children - including Attention Deficit Hyperactivity Disorder (ADHD)

2.1.2.10 Learning difficulties - including references to learning disabilities, and children with dyslexia, dyspraxia and special needs

2.1.2.11 ‘Psychotic’ - including references to schizophrenia, paranoia, ‘split personality’

2.1.2.12 Trauma - including references to psychologists dealing with people who had been through trauma

2.1.2.13 Stroke - including references to psychologists dealing with stroke victims

## 2.2 AETIOLOGY OF PROBLEM: Models of cause of psychological problems

2.2.1 Distal experiences – experiences from long ago as causal of problems, e.g. childhood

2.2.2 Proximal experiences – recent experiences as causal, e.g. breakdown of relationship or bereavement

2.2.3 Medical illness – medical condition as causal (not sufficient to say mental illness; must give sense of something as medical/biochemical; not brain dysfunction)

2.2.4 Brain dysfunction – as causal

2.2.5 Systemic or social causes – cause as due to dysfunction of a system; events in society; changes in society

2.2.6 Thinking errors – errors or irrationalities in thinking as causal

2.2.7 Congenital cause – born with it

## 2.3 LOCUS OF PROBLEM: Attributions about the locus of psychological problems

### 2.3.1 Internal attributions – locating problem within the individual

- 2.3.1.1 Intrapsychic deficit – problem located in mind of individual as a deficit or deficiency
- 2.3.1.2 Behaviour – problem residing in individual's behaviour
- 2.3.1.3 Neurological deficit – problem located in individual's brain as a physical deficit

### 2.3.2 External attributions – locating problem externally to individual

- 2.3.2.1 Stress model – problem residing in impact of external personal events on individual
- 2.3.2.2 Interpersonal relationships – problem residing in relationships between people, e.g. families or couples

## **PARENT NODE 3: PROCESSES INVOLVED IN PSYCHOLOGY**

### 3.1 PROCESSES INVOLVED DURING PSYCHOLOGY: What happens during psychology, in sessions with a psychologist; what processes are salient when they go about their work

- 3.1.1 Talking
- 3.1.2 Questioning
- 3.1.3 Delving/digging/looking into/reading mind or thoughts
- 3.1.4 Listening
- 3.1.5 Engendering of trust/opening up
- 3.1.6 Test administration

### 3.2 PROCESSES WHICH MAKE PSYCHOLOGY EFFECTIVE: What is mechanism of action of psychology; how does it work; what is agent of therapeutic effect

- 3.2.1 Expert models – psychologist placed in active role, as active therapeutic agent; client as passive recipient of expertise
  - 3.2.1.1 Advice giving – psychologist gives advice to be followed
  - 3.2.1.2 Problem solving – psychologist solves client's problems for them

- 3.2.1.3 Thought correction – psychologist corrects or orders thoughts or mind for client
- 3.2.1.4 Medication – psychologist gives medication
- 3.2.1.5 Calm & relax – psychologist calms client or teaches them relaxation
- 3.2.1.6 Complementary medicine – psychologist achieves effect by practicing alternative therapies, e.g. hypnosis; reflexology
- 3.2.1.7 Simple/magical – psychologist applies a simple or magical solution that they possess
- 3.2.1.8 General – general allusion to psychologist as active expert, doing something unspecified for or to the client

3.2.2 Collaborative models – models which attribute therapeutic effect as due to a collaborative process between psychologist and client

- 3.2.2.1 Insight & self cure – facilitated by right questions from psychologist
- 3.2.2.2 Active participation – importance of active participation of client for therapeutic effect
- 3.2.2.3 Sounding board – psychologist as objective listener or sounding board for client
- 3.2.2.4 Perspective – client’s views shift to alternative perspectives through sessions
- 3.2.2.5 Talking – therapeutic effect due to talking with a professional
- 3.2.2.6 Catharsis – effect due to catharsis of emotion
- 3.2.2.7 Match – match between psychologist and client necessary for therapeutic effect; they need to ‘click’

## **PARENT NODE 4: THE PSYCHOLOGIST**

4.1 PROFESSIONAL ANCHORS: professional groups to which the psychologist is anchored, linked or compared. Must be named as nouns, e.g. counsellor, not counselling; psychoanalyst, not analysing

- 4.1.1. Psychiatrist
  - 4.1.1.1 Same as psychiatrist
  - 4.1.1.2 Different to psychiatrist
- 4.1.2 Type of doctor
- 4.1.3 Counsellor
  - 4.1.3.1. Same as counsellor
  - 4.1.3.2 Different to counsellor
- 4.1.4 Therapist
- 4.1.5 Shrink
- 4.1.6 Psychoanalyst
- 4.1.7 Social worker



- 4.1.8 Careworker
- 4.1.9 Educational psychologist
- 4.1.10 People with a title – e.g. lawyer; politician
- 4.1.11 People who give physical help
- 4.1.12 Miscellaneous – other idiosyncratic anchor figures/professions

4.2 NON-PROFESSIONAL ANCHORS: non-professional people or informal helpers to which the psychologist is anchored, linked or compared.

- 4.2.1 Friend :-      4.2.1.1      Same as friend  
                          :-      4.2.1.2      Different to friend
- 4.2.2 Family :-      4.2.2.1      Same as family  
                          :-      4.2.2.2      Different to family

4.2.3 Type of advisor – role model; mentor; peer; someone who has had similar experiences; someone who has had extensive life experience

#### 4.3 PSYCHOLOGIST’S ROLE IN SOCIETY

- 4.3.1 Social control related to Mental Health Act, e.g. involuntary detainment; sectioning; institutionalisation
- 4.3.2 Status symbols for the wealthy or for Americans
- 4.3.3 General authority figure in the social hierarchy

#### 4.4 UTILITY OF PSYCHOLOGISTS: Utility value of psychologists

- 4.4.1 Useful or helpful
- 4.4.2 Not useful or potentially harmful
- 4.4.3 Ambivalent as to their usefulness

4.5 PERSONALITY CHARACTERISTICS OF PSYCHOLOGIST: What kind of person is the psychologist; achievements; personality traits or characteristics

- 4.5.1 Educated and/or intelligent
- 4.5.2 Positive personality characteristics – such as kind, caring, objective, impartial, good-hearted, unpressurising, not self-disclosing, down-to-earth, non-judgmental, strong, coping
- 4.5.3 Negative personality characteristics – such as weird, abnormal

**4.6 EMOTIONAL RESPONSES INVOKED BY PSYCHOLOGIST: Types of emotion triggered by seeing or meeting a psychologist**

**4.6.1 Feeling threatened**

- 4.6.1.1 Fear of being thought to be abnormal, mad, weird
- 4.6.1.2 Fear of being analysed, outcome and motive
- 4.6.1.3 Hostile response to thought of seeing a psychologist in terms of contempt or a denial of need
- 4.6.1.4 Feeling hurt or upset at thought of seeing a psychologist
- 4.6.1.5 Fear of appearing foolish or ignorant
- 4.6.1.6 Fear of being locked up
- 4.6.1.7 Fear of subject matter – finding subject matter of psychologist’s job uncomfortable and so fear of having to discuss it
- 4.6.1.8 Fear of having an emotional outburst
- 4.6.1.9 General reference to fear – no explanation given

**4.6.2 Feeling interested or intrigued at what psychologist would say**

**4.6.3 Feeling relief at seeing a psychologist**

**4.6.4 Feeling awed at status of the psychologist**

**4.6.5 Feeling envious of the psychologist’s job**

**PARENT NODE 5: THE CLIENT**

**5.1 STIGMA: references to clients which have negative connotations**

**5.1.1 Direct**

- 5.1.1.1 Explicit – explicit direct acknowledgement that stigma is around as an issue
- 5.1.1.2 Implicit – use of derogatory language regarding clients, e.g. mad, nutter, weirdo, loonie

**5.1.2 Indirect**

- 5.1.2.1 Emotion – expressions of negative emotions at thought of seeing a psychologist, e.g. anger or fear
- 5.1.2.2 Deviance from norms – implication that being a client means being unacceptably deviant from norms, e.g. “Its acceptable to be sent to a normal doctor”
- 5.1.2.3 Not me – stance that it is acceptable for others to see a psychologist, but not for them to do so

### 5.1.3 Challenges to stigma

5.1.3.1 Explicit – explicit direct expression of view that stigma is inappropriate

5.1.3.2 Implicit – alignment against stigmatising view by subtle use of language, such as “I wouldn’t be shocked ...”

### 5.2 POSITIVE: positive or supportive views regarding clients

5.2.1 Healthy – view of seeing a psychologist as a potentially good, positive or healthy move

5.2.2 Sympathy – compassionate views towards clients’ suffering

5.3 NEUTRAL: neutrality or indifference towards clients, e.g. “I wouldn’t think anything about it”

## **APPENDIX VII**

### **DRAFT EXAMPLE OF POSSIBLE INTRODUCTORY AND INFORMATION SHEET FOR POTENTIAL CLIENTS**

We are aware that people are often very unsure what to expect when they consider coming to see a clinical psychologist. We have therefore prepared this introduction in an attempt to address some of the common questions that people have.

One of the fears that people often have is that they might be 'going mad'. We think that this is because in our culture people are always encouraged to try to sort themselves out if they are feeling distressed. If they find themselves not able to do this, they often end up feeling ashamed, blaming themselves and worrying that they are 'going mad'. We have a different view which we hope you will consider. People are complicated, and there are many different reasons why they might feel distressed. In our experience, this is very rarely the person's fault and is almost always triggered by something happening to them. However, this may not always be obvious when it is happening to you. We believe that people do not want to feel this way and want to find a way to sort things out. We therefore see it as a positive and brave decision to come to see a clinical psychologist to try to help them do this, because it is a way of taking an active step towards helping themselves. It does not mean that they are 'going mad'. Clinical psychologists generally see ordinary people who are feeling distressed, although naturally everybody is different, so some people may feel more distressed than others.

Although clinical psychologists may have the title 'doctor' they are not medical doctors, so they do not prescribe medications. Meeting with a clinical psychologist is therefore not like seeing a medical doctor. Instead, clinical psychologists have studied lots of different types of people and have developed and researched lots of theories as to how people sometimes end up feeling distressed. They can therefore help people to learn about these theories so that they can understand more about themselves. Meetings with a clinical psychologist are therefore a working partnership, a sort of team effort. The clinical psychologist brings their knowledge about people, and the person brings their personal experiences, and together they work things out so that the person can make some positive changes in their life. This team effort requires commitment from the person and the clinical psychologist to think between meetings about what has been discussed. Our research shows that it is very important to have a good working relationship between the person and the clinical psychologist. People therefore have a right to expect that the clinical psychologist will listen closely to their concerns and will show themselves to be worthy of their trust.

We hope that this introduction has helped you to know what to expect if you decide to come to see us. We will be able to discuss these things if you decide to come and see us and we would be grateful for any feedback on whether you found this useful. Finally, we are aware that people sometimes worry that clinical psychologists might be a bit strange to do the job that they do. We hope that you will not think we are once you have met with one of us!