WHAT IS MENTAL ILLNESS?
SOCIAL REPRESENTATIONS OF MENTAL ILLNESS AMONG BRITISH AND FRENCH MENTAL HEALTH PROFESSIONALS*

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Abstract:: Mental health professionals are important actors in implementing public mental health policies and in shaping lay representations of mental illness. The research reported in this paper focuses on the social representations of mental illness held by these professionals in Britain and France. In interviews conducted with sixty mental health workers from a range of professional backgrounds the definition of mental illness emerged as a key concern. Evidence for two social representations of mental illness is found - a medical social representation based on the language and assumptions of psychiatry, and a functional social representation which conceptualises mental illness as an inability to cope and function. Within these representations themes of otherness coexist with themes of sameness. The mentally ill are Other because of their different and un-understandable experiences. Simultaneously mental illness is also described as similar to other experiences. Often professionals use these themes to distinguish between psychoses (primarily otherness) and neuroses (primarily sameness). No single understanding of mental illness is dominant. Professional social representations of mental illness appear to be complex and characterised by uncertainty and ambivalence.

SOCIAL REPRESENTATIONS OF MENTAL ILLNESS

Any research investigating social representations of mental illness must take as its starting point the findings obtained by Jodelet (1991). Her in-depth study of a "family colony" in rural France where mentally ill lodgers have lived with families in the community for over a hundred years is one of the most detailed studies conducted within the field of social representations to date. Jodelet describes a community which has

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established a range of customs and unquestioned practices in the ways villagers interact with mentally ill lodgers. Through the routines of daily public and private life villagers establish and maintain a psychic and social distance from their mentally ill lodgers. The penetration of insanity into the private realm of the family home appears to inspire a sense of fear and fragility in the face of such unknown and unpredictable aspects of human life. Implicit in the accounts and observations obtained by Jodelet is a representation of mental illness as threatening. It is this sense of threat which provokes the families in the study to simultaneously enact exclusionary practices and to represent their mentally ill lodgers as different and other, thus ensuring that a sense of separateness and distance between themselves and mental illness is constantly maintained.

Jodelet's respondents have access to modern expert concepts of mental illness through contact with mental health professionals involved in community placements. However their use of these concepts is minimal in their own understandings of mental illness and they draw simultaneously on pre-medical belief systems which suggest the possibility of contagion through bodily fluids and visual contact. Clearly lay understandings of mental illness draw simultaneously on a range of different models and belief systems which derive from the world of "experts" and from historically rooted cultural belief systems.

Work by De Rosa (1987) investigates the figurative nucleus of representations of mental illness held by Italian children and adults by asking subjects to draw a human figure, a madman and to draw as a mad person would. Thematic analyses of these drawings finds a range of images associated with strangeness, deviance and danger. Again it is clear that lay people anchor madness into archaic belief systems. Madness is objectified in images of people who are magical-fantastical, monstrous and social deviant. For example the mad person is frequently drawn as a polymorphous figure, possessed by evil forces, a drunk and a criminal, or more positively as a jester, a clown or an artist. Further Italian work using word association tasks (Serino, 1987) suggests that lay people represent mental illness as abnormal, defined in generally negative terms associated with social deviance, stigma and danger. This is in contrast to physical illness which is associated with suffering and with normality (defined in positive terms associated with personal integrity and social acceptability).

It is clear from this research into lay representations that mental illness is a phenomenon which is viewed negatively, with fear and suspicion. It is associated with abnormality, danger and difference, leading individuals and groups to reject, exclude and separate themselves from the mentally ill. The multiplicity of understandings of mental illness among lay people is also highlighted. No one model of mental illness dominates. Rather, lay people appear to draw simultaneously on a range of "expert" and lay belief systems. As will be shown by the research reported below, this is mirrored by a similar multiplicity of models and understandings among those defined as "experts" in mental health.

Community Care and Professional Social Representations

Care of the mentally ill is currently being radically reformed in many western countries, as institutional care is replaced with care in the community. Within a historical

context of marginalisation of the mentally ill through asylum based care (Foucault, 1967), current moves towards community based care represent probably the most dramatic change in societal reactions to mental illness since the beginnings of confinement in the seventeenth century. Rather than exclusion, the ideal of community care requires integration of the mentally ill into mainstream society and tolerance of this new position by the public. Set in the context of the representations described above, this is a significant challenge to historically established social representations of mental illness. The findings obtained by Jodelet (1991) suggest that tolerance and integration of the mentally ill will not be achieved easily and that there may be public resistance to the imposition of this new relationship with mental illness. If community care is to be successful there must be significant changes in lay representations of mental illness.

These new policies also have important implications for those who work with the mentally ill. The shift from institutional to community based care represents a major challenge to the established working practices of mental health professionals in Britain and France where community care policies are being implemented within broadly similar public mental health systems.

The research reported in this paper aims to provide a conceptualisation of this situation using the theory of social representations. The working model underlying the research is that professional groupings can be characterised in terms of their social representations of the object of their work - in this case mental illness. These will be termed "professional social representations" and can be distinguished from other social representations in that they emerge from a unique relationship between representors and what is represented (i.e. mental illness). Three features of this relationship can be identified: First, mental health professionals are in more direct contact with the mentally ill than the average lay person. Their representations are therefore shaped by personal experience. Secondly, their professional training has equipped them with a body of theoretical and abstract knowledge concerning, in the case of mental health professionals, the causes and treatment of mental illnesses. Finally, professional social representations develop within an organisational context, and as such can be detected at all levels of institutional practice, from the daily work of practitioners to the design and organisation of hospital wards and community centres. The theoretical and abstract knowledge contained in professional social representations implies that they could be thought of as part of the reified universe of experts conceptualised by Moscovici (1984), although their action orientation, it could be argued, also links them simultaneously to representations circulating in the consensual universe.

METHODS

Sixty semi-structured interviews were conducted with professionals working in British and French mental health services (thirty in each country). Interviews were centred around daily work with clients, and theoretical understandings of the nature, causes and treatment of mental illness. Respondents were sampled from the full range of mental health professionals working in the two countries. The sample included psychiatrists, psychiatric nurses, clinical psychologists, social workers, occupational therapists, plus various educational and therapeutic specialists. Respondents worked in hospital and community based services in similar urban and suburban areas of Paris and

London. (In France the 15eme and 4eme secteurs, Seine-St-Denis, and the 1er secteur, Paris; in Britain the District Health Authorities of West Lambeth, and Lewisham and North Southwark.) These can be characterised as covering poorer suburban areas and socio-economically mixed inner city areas.

The findings presented below are derived from a thematic content analysis of interview transcripts using NUDIST (Richards, 1992), a computer package for qualitative data analysis. The quotes presented are selected on the basis that they reflect themes common to several respondents, or that they express a certain theme particularly well. Quotes from French respondents are translations.

Concepts of Mental Illness

Concepts of mental illness - its nature and status - are central to the social representations of professionals whose work involves care and treatment of people suffering from mental health problems. In interviews with mental health professionals the issue of "what is mental illness" emerged as a central concern. When asked to describe their daily working practices and the theoretical models underpinning these, respondents frequently brought up the issue of what mental illness is. They were also asked explicitly how they would describe mental illness. The analysis described below focuses specifically on the question of how mental health professionals conceptualise mental illness. It does not consider other aspects of professionals' social representations such as their theories of causes and treatment of mental illness, which will be the focus of future reports.

Findings are presented in two sections. Firstly two ways of representing mental illness found in the data are described. These are referred to as medical and functional representations of mental illness. This is followed by a discussion of the themes of otherness and sameness which exist simultaneously in these representations and are often used to distinguish between different types of mental illnesses.

Medical and Functional Social Representations

In talking about mental illness, both British and French respondents make frequent use of terms derived from psychiatric and medical understandings of mental illness. Terms such as "schizophrenia", "manic depression", "personality disorder" etc. which imply a specific symptomatology according to internationally agreed classification systems such as DSM-IV (American Psychiatric Association, 1994) are used by respondents from all professional groups. Not surprisingly psychiatrists make most use of the language and models of psychiatry. The most commonly used terms are "neurosis" and "psychosis" which appear in 75% of all interview transcripts. Historically the medical / psychiatric model has been dominant among those that society has recognised as mental health experts. Throughout the recent proliferation of theoretical approaches and professional groups involved in care of the mentally ill psychiatric terminology appears to have remained dominant. The language of psychiatry has become part of professional social representations of mental illness, aiding communication between the diverse range of professionals who form today's multi-disciplinary mental health teams. Professionals who share a common terminology can

agree (more or less) what problems a particular client is suffering, even if they disagree on the causes and treatment of these problems. As a British psychiatric nurse puts it:-

> "I think symptoms and diagnoses are all very handy for giving a name to a collection of problems that a client is suffering. So its a name we can all agree on, therefore we know what we're talking about when we use it. That in a way is its main function."

However use of terms derived from the psychiatric / medical approach to mental illness cannot be taken simply as an indicator of subscription to a medical representation. It appears that while the medical model of psychiatry provides a dominant and much used way of anchoring mental illness into medical theory and practice, this conceptualisation does not go unchallenged. The medical social representation of mental illness is far from established across the range of mental health professionals. Professionals are actively involved in questioning, challenging, renegotiating and rejecting the medical representation of mental illness. For example they challenge the associations with physical illness that the psychiatric model implies:-

> "It's true that I don't feel comfortable with the term mental illness and if pushed I would even reject it. It has too many associations with medicine, with physical illnesses - flu, diabetes, things like that. So I prefer to talk about madness more than mental illness." (French psychiatrist)

Similarly, as the following quotes illustrate, they challenge the medical models' associations with abnormality and its negation of the diversity of individual experiences:-

> "One of the reasons why I don't use the term mental illness or disagree with it, is that I think for me when someone's in distress or they are coming with symptoms, that those symptoms are all things that make sense, and I think if you call it an illness you're almost trying to make it something that doesn't make sense.....You know, its something wrong so let's make it better." (British occupational therapist)

> "It must be said that the notion of 'mental illness' is itself something which one should have a critical view of. Because the word 'illness' doesn't take full account of psychic suffering." (French psychiatrist)

> "I think psychological problems vary enormously and some of them fall into what I would traditionally call psychosis and some are what have in the past traditionally been called neurosis. Although I think that's a very dangerous and sometimes useless way of actually conceptualising mental health, because again it doesn't tell you about the person and the problems or how they fit in and what meaning they have for that particular person." (British clinical psychologist)

Professionals appear to be actively involved in negotiating their own position in relation to the medical social representation of mental illness which has been historically dominant and which provides the language of communication between professionals. It is clear, as Billig (1993) and Rose et al (1994) stress, that social representation formation and circulation involves active negotiation and debate amongst those who use and consequently transform these representations in their daily activities.

If many mental health professionals are uncomfortable with the medical / psychiatric understanding of mental illness, what alternative understandings of mental illness have they developed? The interviews conducted in this research show evidence of what can be termed a functional social representation of mental illness. This conceptualises mental illness primarily as an inability to cope or function. What is central is not symptoms but the impact these have on a person's ability to live a satisfactory life. Mental illness is described as an individual's inability to copy with aspects of personal or social life, or as

a loss of functioning relative to what is acceptable to that person or to the norms of society. For example:-

> "Mental illness or mental ill health, the concept I suppose is that an individual who is mentally unwell is unable to function in society to a level where they can actually survive most of the time or be on a par most of the time with other people." (British community psychiatric nurse)

> "What is mental illness? A disorder which prevents people from working, living, establishing relations with other people and which leads them to .... That's not a psychiatric answer but that's how I would see it." (French psychologist)

> "It's perhaps the moment at which a patient no longer manages to cope with their life on their own. It could be a reaction to a shock, a trauma or caused by something in their family. But something which means that at a certain point that stops and the person looses control of their life a bit. In any case, they are people who are in distress, who express suffering and who have difficulties in living." (French psychiatric nurse)

Functional understandings of mental illness appear with equal frequency among professionals in both countries. They are most frequently expressed by psychiatric nurses, social workers and occupational therapists. This highlights the link between subscription to a certain social representation and its development and use in daily practice: it is these professional groups who are currently most involved in the personal and social functioning of mentally ill clients. We might speculate that this functional social representation has developed relatively recently as the roles of mental health professionals have expanded from simple medical management to assistance in all areas of personal and social life. A functional understanding of mental illness is certainly congruent with present day community care policies in which the role of the professional is to help clients function and maintain themselves in their normal social settings. Perhaps this type of understanding of mental illness will become more prevalent among professionals in the future, as they take on and accept the new working styles of care in the community.

OTHERNESS AND-OR SAMENESS

The theme of Otherness and difference is one that has been found consistently in the work on lay representations of mental illness described above. Similar themes are found in professionals' descriptions of mental illness and their work with the mentally ill:

> "It (mental illness) is someone who is not their normal self, who is not themself any more, who is different. Someone who doesn't know what he is doing any more - who has lost a big part of himself. I think they are very ill and very ill at ease, and as well they mustn't feel the same as other people, as people who are on the other side of normal life, which must be distressing." (French day hospital worker)

> "A great word when you're going through your training is empathy. I don't think I can ever honestly empathise with somebody who is mentally ill. I can't experience what it's like to have auditory hallucinations. Everybody has a certain degree of paranoia, but I don't think anyone can experience what actual pathological paranoia is. So I think you can only do your best, you know - you can only try and assume what that person is feeling, but I don't think you can ever take on board what that person's experience really is. It's not a real experience, you know, you can't possibly understand what a mentally ill person is going through." (British psychiatric nurse)

Similar expressions of a sense of otherness are found across the range of professional groups in both the British and the French sample. Nurses in particular are more likely than other professionals to express themes of otherness. This parallels work in Italy

(Bellelli, 1987) which suggests that psychiatric nurses distance themselves from the mentally ill more than psychiatrists and psychologists. Two possible explanations for this finding can be suggested: The daily work of psychiatric nurses involves almost constant contact with the mentally ill, compared to other professionals whose contact is much more time limited. Perhaps, similar to the villagers in Jodelet's study (1991), daily physical proximity with the mentally ill leads nurses to enhance the sense of Otherness in their representations of mental illness, thus maintaining a "safe" psychosocial distance between themselves and the mentally ill. An alternative explanation is that nurses' representations may be closer to those of the general public in which a sense of otherness is paramount. This may be due to their less in-depth theoretical training compared to other professional groups (although with the increased professionalisation of nurses this last point may no longer hold true).

The second of the above quotes illustrates the nature of the sense of otherness expressed by these respondents. Difference and otherness appear to be defined phenomenologically. In other words otherness arises from a sense of alienation and an inability to imagine what the experience of mental illness is like. The mentally ill are represented as different and other because they are thought to experience the world differently and have a different way of being, which representors feel unable to understand using their own models of the world and past experiences. As this respondent points out, this places the professional in a paradoxical position. A sense of otherness based on differential experiences opposes the expectations that professionals' work involves sympathetic understanding of their clients.

Perhaps it is the role of mental health professionals as "experts" who are expected to understand and care for the mentally ill, that imbues their representations of mental illness not only with a sense of otherness, but also with themes of sameness. In their daily work, mental health professionals are in a unique position of proximity to what is socially represented as dangerous, threatening and different. Yet they choose to place themselves in this position, and in so doing aim to understand and care for their mentally ill clients. Themes of the similarities between mental illness and other experiences occur almost as frequently as themes of otherness (in around one third of interviews across all professional groups in both countries). The similarities between the mentally ill and other people are acknowledged in the recognition of the potential for mental illness in all people, oneself included. For example:

> "I think there is the potential in everybody to become mentally ill, every single one of us. Just thinking about things like feeling depressed, I feel that, you know we all have bad days, we have days when we feel a bit upset, and things happen to us in our lives that upset us. Like you run out of money at the end of the month, or you fall out with your friend or you have lots of bills coming in all at one time that you can't manage to pay, and you get a bit down about it. But I feel that mental illness is kind of an extension of those things really. An extension of feeling down." (British charge nurse)

> "It's a continuum from what normal life experiences are. The problem is defining what is normal I guess. So there's no easy answer to that. An exaggeration of perhaps many things that occur for people who are normal in inverted commas. An exaggeration of some of their behaviours, some of their emotional responses to things." (British clinical psychologist)

As with otherness, sameness is defined in terms of an ability to imagine and empathise with the mentally ill person's experiences and feelings. The most common

experiences which professionals associate with mental illness are distress, fear and loss of control:-

> "Whatever the cause, the effect is intense distress and emotion - emotional distress. And loss of control. It's frightening, it's very frightening to the individual. That is probably the common factor across the various types of mental illness, so called." (British psychiatric nurse)

> "To be mad is to loose control, to be frightened, to be distressed, to be unable to put up with it and control it any more, not being able to live any other way or find any other solutions." (French psychiatric nurse)

Although themes of otherness and sameness coexist in mental health professionals representations of mental illness, some patterns also emerge. Sameness and otherness are often used to distinguish between neuroses and psychoses. The sense of otherness appears to be activated particularly by what mental health professionals label as psychoses. Psychoses are described as qualitatively different experiences which other people can only have limited understanding of. Neurotic illness on the other hand is often described as akin to, or an exaggerated form of normal experience, which respondents can imagine or even experience themselves. The following comments are typical of the types of distinctions made:-

> "There are parallels between what goes on in neurosis and what goes on in psychosis but it seems to me that the two are different. I might have, say, an overvalued idea, a bee in my bonnet about something which might be similar to a psychotic who's got a delusion but they're not the same. So I find the borderline between what we would say is mental illness and normality very difficult to define. I suppose I feel that at some stage someone who is psychotic passes through some kind of barrier which is beyond the ordinary, the acceptable neurotic experience. There's something about neurotic experience which is comprehensible to all neurotics, and yet there are aspects of psychosis - this is an idea of Jaspers - which are incomprehensible, which is beyond our understanding." (British psychotherapist)

> "The patients, especially the psychotics, the schizophrenics, they are quite simply on another planet, they live on earth, but they're strangers on earth." (French psychiatrist)

In contrast the same respondent describes "neurotics" as

> "People who simply have difficulties coping with their inner drives, but they are perfectly grounded on this earth."

A French social worker describes neurosis as

> "C'est la folie du mec normal" (Its the madness of the normal guy)

Such distinctions between psychoses as otherness and neuroses as sameness may derive from the psychiatric / medical model of mental illnesses. Psychiatry has traditionally differentiated between psychosis and neurosis in terms of loosing touch with external reality, assumed to be a characteristic of the former but not the later state. Distinguishing between psychoses and neuroses fits much more with medical social representations of mental illness than with functional representations in which such distinctions are not made.

Comparing these findings to studies of lay representations of mental illness, there is one striking omission. The explicit sense of fear and threat which accompanies otherness in lay representations is not expressed among mental health professionals. Whether this is due to self presentation in the interview context, in which respondents' professional identities allow little space for explicit fearful reactions to mental illness, or reflects the fact that professionals are actually less fearful of the mentally ill is debatable. However

the implicit creation of distance and boundaries between professionals and clients in taken-for-granted daily working practices suggests that some degree of fear and threat does characterise professionals' reactions to mental illness. For example, the segregation of eating and toilet facilities and staff only areas is common practice in many hospital wards and even in newly constructed community day centres. Such unquestioned exclusionary practices parallel the findings of Jodelet (1991). In the organisation of daily practices and in respondents' frequent references to the stressful nature of their work, we can obtain glimpses of a non-verbal reaction to mental illness amongst mental health professionals which is inaccessible in the interview context.

Discussion

The findings presented above suggest that, as with lay representations, professional social representations of mental illness are diverse and characterised by uncertainty. No one fixed understanding of mental illness dominates professionals' understandings of the object of their work. Instead representations are multiple and encompass a range of oppositional and often contradictory reactions to mental illness. Professionals understand mental illness in a range of ways, drawing simultaneously on medical and functional representations and conceptualising mental illness as both sameness and otherness. Despite their status as mental health "experts", respondents' basic understandings of what mental illness is appear to be far from securely anchored; their social representations are characterised by much debate, questioning and negotiation. Where the boundaries of mental illness lie, and what defines an illness are issues which confront mental health professionals every day in their practical work, and which neither training nor experience seem to provide clear cut answers to. Perhaps it is because professionals recognise the complexities and diversities of experience which the umbrella term mental illness encompasses that their understandings of mental illness are multiple and heterogenous.

These findings also suggest that there is considerable ambivalence in the social representations of mental illness held by mental health professionals. Interview respondents express a range of often oppositional reactions to mental illness. The mentally ill are frequently described as Other in that they inspire a sense of alienation and inability to imagine their experiences. This reaction is particularly associated with what mental health professionals term the psychoses. Simultaneously themes of sameness and a sense of empathy and compassion towards the distress of the mentally ill are also expressed.

Conceptualising mental illness as Other has the effect of distancing and separating the mentally ill from oneself and one's social group. In contrast, themes of sameness provide a link between the self and the experiences of the mentally ill, drawing mental illness psychologically closer. The way mental illness is socially represented has the effect of widening or narrowing the difference between the representor and what is represented. Among mental health professionals the current findings suggest that mental illness is not in a fixed position, but one which fluctuates between psychosocial closeness and distance. Such ambivalence may derive from their unique relationship with mental illness. As "experts" in mental health, professionals are expected to understand the problems of their mentally ill clients. Yet at the same time they are not immune to

prevailing lay representations which conceptualise mental illness as dangerous and threatening. Social representations may serve a compromise function for professionals, helping them to reconcile their ambivalent reactions to mental illness with the demands of their work and providing a guide to their interactions with mentally ill clients which is both psychologically and socially acceptable. Similar oppositions at the heart of social representations have been found in other studies where the relationship between representor and what is represented is complex. For example Giami (1987) reports that parents' representations of their mentally handicapped children show oppositional themes of 'angel' and 'beast', associated respectively with innocence and the threat of sexuality.

A further theoretical consideration inspired by these findings surrounds the concept of unfamiliarity. A basic premise of the theory of social representations is that they function to make the unfamiliar familiar. Moscovici (1981, p189) states that "the act of re-presentation transfers what is disturbing in our universe from the outside to the inside, from a remote to a nearby space." Yet in social representations of mental illness (especially lay representations) themes of otherness ensure that, although the mentally ill are familiarised to the extent of being given a position in the social world, they nonetheless remain distant and unfamiliar. Furthermore, unlike for example AIDS or biotechnology whose unfamiliarity derives from their novelty, the marginalised social position of mental illness throughout history has ensured that unfamiliarity has remained an enduring feature of its social representation. In this case perhaps we could say that social representations familiarise mental illness as unfamiliar[1]. There is clearly space for unfamiliarity within some social representations. In the case of mental health professionals' representations of mental illness, unfamiliarity coexists with familiarity at the heart of the representation. It is to be hoped that such findings will inspire more thoughtful consideration of the concept of unfamiliarity in the theory of social representations. Perhaps we could usefully differentiate between unfamiliarity derived from novelty, and unfamiliarity derived from a marginalised social position allocated to those phenomena which are particularly threatening and fearful to individuals and to societies.

The data on which these findings are based were obtained in two different cultural contexts -Britain and France. Yet in investigations centred on the question of what mental illness is no significant cross cultural differences have been detected. This suggests that at their heart, social representations of mental illness are relatively consistent cross-culturally, at least within broadly similar European cultures. Despite this, there are some significant differences between the two countries in professionals' use of theoretical models of the causes and treatment of mental illness. In particular, psychoanalysis has had a huge influence among French mental health experts and in French society as a whole (Castel & Le Cerf, 1980), while its impact has always remained marginal in Britain. Conversely, the use of psychological models, especially cognitive and cognitive-behavioural styles of treatment has tended to be much more widespread in Britain than in France. These findings suggest that French and British

[1] I am grateful to my colleague at the London School of Economics, Diana Rose who originally proposed this concept.

mental health professionals use different theoretical approaches to mediate their understandings of what, on a fundamental level, they represent in the same way.

To conclude, the coexistence of both medical and functional understandings of mental illness used simultaneously by the respondents in this research reflects the current situation in public mental health services in Britain and France: While the historically dominant psychiatric model still has considerable power and forms the basis of the language of communication between a diverse range of professionals, a functional model of mental illness which is more congruent with community based care is also a common way of conceptualising what mental illness is. This suggests that the concept of professional social representations can be a useful tool in understanding the complex interactions between institutional changes and the daily practice and belief systems of individuals in dynamic organisational settings.

The results obtained in this research represent a snap-shot of a rapidly changing world in which public and professional relationships with the mentally ill are being constantly renegotiated. If we accept that "the character of social representations is revealed especially in times of crisis and upheaval" (Moscovici, 1984, p54) this would appear to be a particularly important time to conduct research into public and professional representations of mental illness.

How both lay and professional social representations of mental illness will change in the coming years as care of the mentally ill in the community becomes the norm, remains to be seen. The findings obtained by Jodelet (1991) alert us to the fact that even in situations of apparent integration, lay people persist in using subtle but powerful ways of excluding the mentally ill. However perhaps the themes of empathetic understanding, compassion and sameness expressed in the present study by mental health professionals are grounds for some optimism. Professional social representations interact both with lay representations and with changing government policies. Through the daily work of mental health professionals the public and the mentally ill themselves are directly confronted with the impact of hospital closure and community based care. It is to be hoped that lay representations will be gradually transformed to incorporate a level of acceptance and understanding of mental illness which is essential for the successful implementation of community care. Whether this is achieved or not, one thing is clear - social representations of mental illness are multiple, complex and encompass a range of ambivalent reactions.

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