Unification and differentiation: a study of the social representations of mental illness

Juliet Foster

Faculty of Social and Political Sciences
University of Cambridge,
Free School Lane
Cambridge, CB2 2RQ
U.K.1
Email: jlf1000@cam.ac.uk

Using the theory of social representations, this small-scale, qualitative study considers whether mental illness is differentiated by a lay population. Three focus groups (total n=17), using students were conducted and content analysed, along with a random sample of articles from two British newspapers, 'The Mirror' and 'The Daily Telegraph'. A strong social representation of unified 'mental illness' was found, with the central aspects of unpredictability, permanency, violence and Otherness. However, differentiation of mental illness in social representation was also found, both along biomedical lines, and through the idea of a set of continua between the more normal and the more mentally ill. It will be suggested that differentiation occurs in today's society due to efforts to maintain both existing ideology and a positive identity, but that any condition that can be labelled 'mental illness' will also be inevitably associated with the unified representation of mental illness, limiting the effect of this differentiation. It will be concluded that differentiation of mental illness has been somewhat overlooked in social representations studies, and merits further attention from a theoretical perspective.

Introduction

This paper discusses the results of a small-scale study investigating differentiation in social representations of mental illness in a student population.

Public understanding of mental illness has been considered from a variety of perspectives, including attitude/public opinion work (Johannsen 1969; Maclean 1969; Rabkin 1972; Crocetti, Spiro et al. 1974; Rabkin 1974; MORI 1979), 'lay beliefs' (Rippere 1977; Rippere 1981; Furnham 1984; Furnham and Rees 1988), geneology (Foucault 1961/1995), and social representations theory (De Rosa 1987; Räty 1990; Jodelet 1991; Rose 1996). The majority of these studies conclude that mental illness is viewed extremely negatively, and the mentally ill seen as violent, unpredictable and irrevocably"Other" (Nunnally 1961; Maclean 1969; Miles 1987; Gilman 1988; Jodelet 1991; Rose 1996). These negative attitudes appear both strong, and historically tenacious (Sarbin and Mancuso 1970; Rabkin 1974; Hall, Brockington et al. 1993).

One question, however, that has been somewhat overlooked is that of differentiation in understandings of mental illness amongst the general public: is mental illness regarded as one generic category, or is it divided into different conditions? Secondly, if there is differentiation, does this parallel medical thinking, or other lines of lay knowledge?

Several factors point to the existence of differentiation in public understanding of mental illness.

Firstly, previous research in different areas has found evidence of differentiation. Nunnally (1961) found that neurotics were seen as weaker, and psychotics were liked less; Jodelet's (1991) villagers divided their lodgers from a local mental hospital into five types, from the child-like 'innocent', born with mental illness, to the 'crackpot', a more recent criminal phenomenon; using multi-dimensional scaling, Stockdale and Purkhardt (1993) found that mental illness was divided into four distinct groups in public representation – anxiety, depression and paranoia were significantly separated from Multiple Personality Disorder (MPD), schizophrenia and psychopathy, for example. Some theorists seem to presuppose the existence of differentiation from the outset, and pre-divide mental illness themselves in their research, usually into its medical categories: such studies have found that the public appear to have more negative attitudes if asked about schizophrenia (Appleby and Wessley 1988; Furnham and Rees 1988) than about depression (Rippere 1977; Rippere 1981).

Secondly, professional understanding of mental illness is highly differentiated, as shown by diagnostic manuals (World Health Organisation 1993; American Psychiatric Association 1994) and textbooks on psychiatry (Gelder 1983) and psychology (Davison and Neale 1994). Research into professional social representations supports this: Morant (1995; 1996) found that mental health professionals divide mental illness into more understandable neurosis and more incomprehensible psychosis.

Lastly, other areas of health are differentiated in public understanding, as both studies using social representations theory (e.g. Joffe 1995; 1996 on HIV), and other studies (Sontag 1978, on cancer and TB) show. If health can be differentiated in public understanding, can mental health?

Using the theory of social representations

Social representations theory was employed in this study for several reasons: firstly, there is a strong tradition of work using the theory in the area of mental illness, as shown by the studies cited above. There have, of course, also been substantial contributions from other

areas, such as attitude theory, but such a perspective is too static (Moscovici 1963), and fails to give sufficient access to meaning.

Access to meaning is particularly important in the current study: as the brief review of the literature above indicates, it appears that people might differentiate on some level in their representations of mental illness, but it is much less clear how this differentiation might manifest itself, or why it might exist. Social representations theory, with its emphasis on process and content, allows closer consideration of this topic from an interpretivist perspective, in a way in which other theories of knowledge or attitudes might not.

Similarly, social representations theory provides a useful forum for examining the development of everyday knowledge of mental illness: Moscovici (1984) describes how scientific knowledge enters the everyday domain: might the differentiation found in psychiatric professionals' representations of mental illness have influenced public representations? If so, how has it been transformed from professional to public representation? Individuals and groups do not passively encode and mirror the representations held by other groups, but actively work through them, changing them as they do (Jovchelovitch 1997). Unlike many other theories of lay knowledge, social representations theory refuses to privilege one representation over another, or to see differences as the results of error or bias. This is crucial when examining issues such as mental illness, where a significant power differential exists between groups holding representations: psychiatric knowledge occupies a position of considerable power, in that psychiatrists are granted the power to define the normal and the abnormal (Morant 1998). A theory of knowledge which allows for the existence of other forms of knowledge, and does not judge these against one another is essential: participants must feel free to express ideas other than 'accepted' medical versions. In parallel, however, social representations theory allows acknowledgement of the ontological aspects of representation: historical analyses of beliefs about mental illness (for example, Foucault (1961/1995), demonstrate the weight of enduring and negative images of mental illness on individuals and groups through the ages.

Lastly, it has been argued (Rose 1996; Rose 1998) that mental illness represents a failure to familiarise the unfamiliar in representation: mental illness remains feared, and may therefore be familiarised *as* unfamiliar (Morant 1996). Considering whether mental illness is differentiated in representation might begin to add to this debate. Do we fail to familiarise mental illness in our representation, or is it possible that some aspects of mental illness might be familiarised more than others?

Methodology

Two methods were employed in this study, focus group interviewing and media content analysis, in an attempt to triangulate the data through accessing different perspectives (Flick 1992), and to access representations operating at the microgenetic level through conversation and at the sociogenetic level through the media (Duveen and Lloyd 1990).

Focus Groups

Focus groups were chosen over individual interviews in that, as a social situation, they are often more appropriate for studying the social phenomenon of social representations (Farr 1993; Livingstone and Lunt 1996). Three focus groups (n=17) were held with different types of undergraduate student. The first focus group comprised students from a London drama college, none of whom had any background in psychology; the second was held at an East Anglian University, and comprised students taking an introductory course in psychology; the

final group was held at a London University, and was made up of students taking their Final Exams in Psychology. All students were contacted through posters advertising the project, or through word-of-mouth. These groups were chosen to examine the possibility of the diffusion of professional representations into public representations. Zani (1993) suggests that psychology students maintain less social distance between themselves and the mentally ill than other students: could psychology students be considered akin to amateur scientists, diffusing aspects of professional knowledge into the public?

At each group I employed a flexible question guide that moved from the general to the specific (see appendix1): I was concerned not to explicitly ask about differentiation, as I felt that this would influence the results. Questions were asked about 'mental illness' in general, as in other studies in this area (Jodelet 1991; Morant 1996), after which a series of cards were introduced (see appendix2). Vignettes have been employed very successfully in much research into mental health (Cumming and Cumming 1957; Brockington, Hall et al. 1993), including some that employs social representations theory (Wagner et al 1999). The cards featured pieces of information that one might find in a volume such as DSM-IV (American Psychiatric Association 1994), but each was contestable, and non-gender specific. Participants were invited to discuss their reactions to the cards, such as whether they might describe someone with mental illness.

Newspapers

Two British newspapers were chosen for content analysis purposes: one tabloid, 'The Mirror', and one broadsheet, 'The Daily Telegraph'. 'The Mirror' is traditionally a more working-class, left-wing newspaper, which drew a readership of 6 million in 1996-1997 (Matheson and Pullinger, 1999), while 'The Daily Telegraph' was the best-selling broadsheet in 1996-1997, with a readership of 2 million (Matheson and Pullinger, 1999), and traditionally attracts a higher class, more right-wing reader.

For the period 28.1.96 - 28.1.98, an FTProfile search for articles referring to mental illness yielded 61 items for 'The Mirror' and 160 items for 'The Daily Telegraph'2. A random number generator selected a sample of 25% of the articles from each newspaper, leaving 16 articles from 'The Mirror' and 40 articles from 'The Daily Telegraph'.

Analysis

The focus groups were transcribed, and read many times along with the sample of articles. All data was entered into the NUD*IST computer-aided qualitative data analysis program, and coded into themes: the 'tree structure' that NUD*IST allows the researcher to develop was useful here, as data was coded into the conditions mentioned, including generic 'mental illness' (the root), and the causes, effects, consequences and miscellaneous details (branches) referred to for each condition. This coding frame broadly follows the categories of Leventhal and Benyamini's (1997) individualistic illness representations theory (identity of illness, causes, consequences, timeline and curability), but was employed flexibly. Text that did not fit these categories was also coded into more data-driven coding units, such as humour, thereby allowing unexpected elements to emerge from the data. A sample of the data was recoded at a later date to ensure that coding had been performed consistently. The results

---

2 It should be noted that this difference in volume of articles on mental illness between the tabloid and the broadsheet does not seem typical: 'The Daily Mail', another tabloid, for example, contained 177 articles on mental illness within the same time frame

were then compared across focus groups and newspapers, and the similarities and differences noted.

Although there were some interesting differences, it was the similarities across groups and between newspapers that were more striking, and it is on this aspect that the remainder of this paper will focus.

Results

Mental illness and mental illnesses

The data indicated the existence of a strong social representation of *'mental illness'*, featuring violence, unpredictability and Otherness. However, differentiated representations of *'mental illnesses'* also exist, both along medical lines and along other lines of understanding.

Despite this differentiation, however, anything that can be linked to mental illness (e.g. depression, anxiety, autism), however much discussion or argument this linkage may entail, will also be connected with the general social representation of mental illness. All mental illnesses are therefore seen as having the potential to lead to unpredictable, incomprehensible violence.

> "A53:'But even though these people are not a danger to anyone but themselves, because we don't know exactly what's going on in their brain, we don't know exactly what's going to happen. They might flip out and do something bizarre, because you can't quantify what's going on in their heads'."

This sub-text of unpredictability, violence and Otherness is frequently reiterated, in focus groups and newspaper articles alike.

> "B2: 'But people are so afraid of reactions with people with mental illness, it's just the unpredictability of it. And abnormal behaviour in social situations, and it worries people and makes them feel like, well, quite, scared, in some ways, I guess. Just pre-empting reactions.'"

> "A recent report found that one murder is committed about every two weeks by mental patients and about 1,000 commit suicide each year" 'The Daily Telegraph' 17.1.98

In these cases, no specific mental illness is mentioned: the message is clear - all those linked to mental illness have the same threatening potential.

Aspects of the social representation of 'mental illness'

I will now briefly examine some of the elements of this representation of generic 'mental illness', before considering further differentiation.

In focus groups and newspaper articles, mental illness was located squarely in the brain. It is therefore encased in a highly sensitive, visually inaccessible and impenetrable matter, making it somewhat mysterious.

> "A4: 'They all come from here [taps head] whether you deem it an illness, something which is negative, or ...'
>
> A8: 'It comes from the brain and it's a disorder, illness.'"

---

3 A=non-psychology students; B=first year psychology students; C=psychology finalists.

This parallels Jodelet's (1991) findings, in which participants saw mental illness as stemming from a failure of the brain, which stops developing when the misfortune occurs.

Interestingly, the mystery   surrounding the brain is expressed through focus group participants' frequent avoidance of saying the words 'brain' or 'mind', here generally equated with one another, and their reliance on body language to convey implied meaning, as shown above.   The brain itself seems to be held in considerable awe.

Despite frequent discussion of the 'nature/nurture' debate, mental illness is commonly referred to as the result of a 'chemical imbalance' in the brain: mental illness is represented as the result of usually harmonious chemicals or hormones becoming unsettled, affecting the brain, and therefore the person whose brain it is.

> "A3:'Another word for mental then. Brain condition?'
>
> A4:'Cranial?'
>
> A3:'Cranial condition' [Laughter]
>
> A5:'Cranial chemical imbalance.' [Laughter]"
>
> [discussing possible different names for mental illness]

However, assigning the cause of mental illness to a chemical imbalance does not necessarily imply that the cause is something wholly internal; this was especially apparent amongst the students with some familiarity with psychology. A chemical imbalance in the body (and almost exclusively in the brain) could either be caused purely internally, through genes or hormones, or brought about through external, social factors, such as traumatic life events.

> "B5:'But trauma doesn't mean it's not chemical, trauma can surely create chemicals.'"

The modern day representation of mental illness as the result of an imbalance of chemicals seems to parallel the representation of the Eighteenth/Nineteenth centuries which inspired the 'moral management' approach to madness. Rose (1985) states that during this time madness was associated with the ducts of the body, and the blood and humours carried within them. Representations of the way in which medication works might be the modern-day equivalent of representations of the way in which cold baths worked on the humours in older societies, re-balancing the unbalanced and realigning the mis-aligned.

However, social factors were also seen as playing an important role in causing mental illness: the interaction between physical and social factors is represented as a kind of 'tendency + trigger' idea: mental illness is represented as being triggered by an event, often something more social, such as bereavement, that activates a previously dormant tendency toward mental illness. This can be used to explain why some people become mentally ill after a traumatic event, and some do not. I believe that this is further evidence that mental illness is socially represented as ultimately biological in cause. Individuals are represented as possessing some organic tendency, again, maybe hormonal or genetic, that predisposes them to particular reactions to certain social events, and consequently to becoming mentally ill.

> "B5:'But at the same time there are people who exhibit symptoms of a mental illness after a painful life event, but, you know, another person could have that happen to them the same, and the same illness wouldn't ensue, so I think there are a lot of background factors and sort of chemistry.'

> B1:'Not... that predetermine you, but that combined with the right kind of triggers might affect you in that kind of way.'"

> "C3:'I'd have to argue that there'd be physical underpinnings and physical effects and causes at all stages, erm and obviously there are triggers in one's life.'"

This parallels Morant's (1996) findings of professional representations of the role of 'resources for life' in the causation of mental illness.

Contrary to De Rosa's (1987) finding that children move from criminalised to medicalised representations of mental illness as they grow older, the adult participants in this study maintained a strong sense that mental illness may be, to some extent, the choice or responsibility of the person involved, something which co-exists in potential contradiction with biological models of causation.

> "B3:'I mean, I've come across people who say that mental illness is an excuse, or depression is an excuse, you know, just for being lazy or whatever.'"

> "A6:'You know, like one day my mind just goes [clicks fingers], right, that's what I'm doing because I can't handle reality. Is that genetic, or is it, you know, just like a way of dealing with things that society doesn't accept?'"

What, then, are the consequences of the fact that mental illness is still, to some extent, and however implicitly, represented as the fault of the person concerned? Having a mental illness can entail guilt. An individual must have behaved in a certain way, or possessed certain tendencies that led to their particular predicament. Mental illness must therefore be hidden, and is viewed as potentially shaming. Mental illness must be concealed, as Goffman (1968) describes the concealment of potentially discrediting information, if stigma is to be avoided.

> "B1:'It can be very hard to get somebody to, kind of, explicitly confess to it.'"

> "B2:'And there's also a feeling of shame associated with it as well. In some way it's their fault that they're not normal.'"

However, paradoxically, there is also a sense that being mentally ill absolves you from responsibility for yourself, your illness and your actions. This is particularly the case in newspaper reports of legal proceedings: crimes can be explained, even justified, if a diagnosis of mental illness is given. We need the explanation that mental illness provides in order to understand a variety of crimes, from rape and murder to corporate fraud, and for other forms of socially deviant behaviour.

> "Israeli reports said he took a bus to Hebron yesterday morning and wandered through the Jewish quarters before deciding to open fire on the Arab market. Israel's Channel 2 television said he had a history of mental illness." 'The Daily Telegraph' 2.1.97

> "Muraglia, of Camden, who has a mental illness, and once bared her bum in court, was in cells yesterday after leaping the dock." 'The Mirror' 31.7.97

> "B3: '[T]here's people who will say at the slightest exhibition of any strange behaviour, 'Oh, there must be some problem here.''"

Reports of criminal proceedings even routinely refer to the defendant's mental health status when they are not diagnosed with any mental illness. This serves to link the idea of crime, especially violent crime, to mental illness even in cases where no link exists.

If mental illness is caused by the combination of tendency and trigger, and is generally explainable by a chemical imbalance in the brain, how does the onset of mental illness manifest itself? How do people make familiar the highly unfamiliar concept of 'going mad'? Some metaphors were used to describe this process, such as 'flipping out', 'snapping', flipping a coin, 'switching off', and the brain 'overheating', all of which imply that going mad is a rapid, even violent event. However, I believe that here language begins to fail us in our social representations, and we become more reliant on other means of expression. De Rosa (1987) argues that the figurative element of social representations may be more social, and more enduring, than the linguistic element: in this study focus group participants consistently employed the same actions to denote the process of developing mental illness.

> "B1:'And a fear that she's always going to [clicks fingers] switch off, I mean that would always be my great fear, like you'd just never, you wouldn't feel totally in control.'"

> "A4:'I mean, a schizophrenic cannot tell when that attack's going to come' [claps hands]"

> "C1:'But with manic depression you have to be like, ...kerchow... you know.'"

This reliance on non-verbal portrayals of 'going mad' might support those who argue that familiarising mental illness is difficult, certainly in terms of naming it.

However, mental illness is not represented as entirely negative: it is seen as occasionally leading to 'extra' qualities. Indeed, there was some discussion as to whether being 'extra' talented might lead to a person developing mental illness in the first place. This idea, and the mystery surrounding the brain, is illustrated in the following focus group extract.

> "A5:'Well, they say that we only tap into a certain percentage of our brains, of the brain. Are these people born with a kind of mechanism that enables them to tap into other areas of their brain? Because there isn't any scientific back-up to help these people in childhood, all this brain energy goes un-harnessed - where it kind of shoots off in all directions and because they don't know, there's no one else around them who has a similar sort of intellect, who can harness that type of brain power...'"

The media plays a significant role in propagating this representation of the genius of madness. Participants referred to cases they had seen on television of gifted artists etcetera. Also during the data collection, the film 'Shine', the story of a gifted musician and his mental health problems, was released, prompting much discussion of the link between genius and madness in the press.

> "The film has invested heavily in the 1960s' idea that the mentally ill may really be more sane than the rest of us. David Helfgott is portrayed as a 'Holy Fool', whose dormant genius survives the tyranny of his father and is revived by the love of a good woman." 'The Daily Telegraph' 11.2.97

This representation of the genius of madness is, again, something that can be found throughout history (Foucault 1961/1995; Porter 1987).

The above results all seem to provide support for the existing literature on representations of 'mental illness', but what of representations of 'mental illnesses'? What evidence of differentiation can be found in the data?

Differentiation

There was considerable evidence that mental illness is also differentiated, into *mental illnesses* in social representation. In this study, differentiated representations exist both along medical lines, and along other lines, specifically based around the idea of sets of continua.

Medical Differentiation

It appears from the data collected in this study that a 'hierarchy' of mental illnesses has arisen within social representations (see figure 1). Morant (1996) found clear differentiation in professional social representations between psychosis and neurosis. In the present study, the separation is not as explicit, probably because fewer lay people share the scientific definitions of psychotic and neurotic, although they have passed into everyday language. In this project, participants made the distinction between what they termed 'lower level' and 'higher level' mental illnesses

```
H       SCHIZOPHRENIA
I                                           AUTISM
G
H       MANIC DEPRESSION
H                               TOURETTE'S SYNDROME
E                               ALZHEIMER'S
R

L                                           SEX OFFENDERS
E
V
E
L

L
O
W               EATING DISORDERS
E
R
        PARANOIA
L
E
V           OCD
E
L       ANXIETY                 DEPRESSION
```
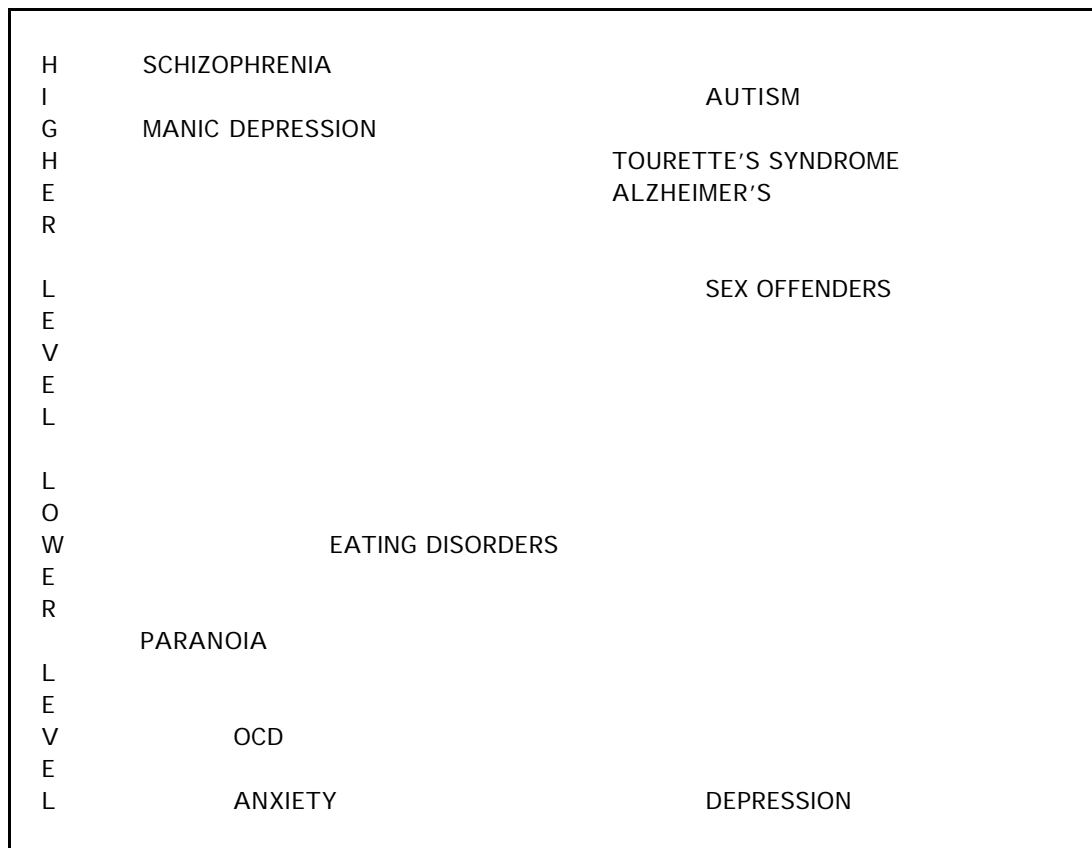
FIGURE 1

A hierarchy of mental illness.

Please note: too much differentiation was apparent to comprehensively present a diagram in two dimensional form. However, mental illnesses have been grouped together according to some similarities that emerged from the content analysis of focus groups and media. The top right hand corner contains mental illnesses that are both high level, and involve social deviance, whereas the top left hand corner involves less deviance. This deviance distinction is not made in the lower level mental illnesses.

These two different types of mental illness were seen as having different characteristics (see table 1)

Medical differentiation, therefore promotes significant differences between representations of lower and higher level mental illnesses in terms of their causation, effect, curability and treatability, and location.

Table 1
Characteristics of types of mental illness

	LOWER LEVEL	HIGHER LEVEL
CAUSES	Social pressures.	Biological; genetic.
EFFECTS	Violence to Self.	Violence, mainly to others Social deviance. Often obvious in appearance.
TREATMENT	Talking therapies NOT drugs (could just suppress issues).	Drugs only.
PROGNOSIS	Good, if social pressures are rectified. Need for personal effort in getting better.	Poor, controllable, not curable. No suggestion that personal effort would help.
EFFECTS ON OTHERS	Sympathy. Empathy.	Fear.
LOCATION	Possibly Self.	Irrevocably Other.

Continua: lines of differentiation

However, medical knowledge does not exclusively account for differentiation of mental illness in representation. I believe that in representation mental illness is objectified using the image of a continuum. People make sense of mental illness by imagining sets of various continua, within which, I would argue, differentiation is implicit.

The most important continuum is that which relates to whether a person can be categorised as mentally ill or not. Any symptom, behaviour or lifestyle can be placed along this continuum.

normality_____mental illness

Individuals, then, may exhibit certain symptoms, and not be mentally ill themselves, as they exhibit a more 'diluted', and therefore more normal form. This is especially the case for those with 'lower-level' mental illnesses, but may also be relevant for elements associated with 'higher-level' mental illnesses.

"B4:'I mean with all of them it's all, I mean, if it was a major degree of unhappiness and then elation then its a kind of illness, but then if you just have a small amount of it then it's kind of normal, so I suppose this means you have a scale, and then it becomes at one point it becomes too much for you, and then its a mental illness.'"

"A5:'But what you do when you have a mental illness is that you're just taking something that we all normally do to an extreme.'"

> "C1:'Sometimes hears voices is a weird one, because don't you sometimes do that when you think someone's called your name and they haven't?'"

This makes some mental illnesses less irredeemably Other per se, and more a possibility for the self.

The severity of a condition can be established according to its position on the following continuum:

$$\text{to self}$$

not harmful_____harmful

$$\text{to society}$$

Some mental illnesses are not considered harmful.

> "C3:'I've got a friend who talks about good numbers and bad numbers,... there are certain letters and certain things that were good and bad... I don't believe she's ever been diagnosed with any kind of illness or whatever, but I think, like, six was a good number, and eight was a bad number. And the thing is, that is obviously mental illness, but it's not, you don't have a problem with anything.'"

It is therefore more difficult to classify what constitutes a mental illness at the 'not harmful' end of the continuum, as this blurs with what might be considered normal. As we reach the other end of the continuum, however, we are faced with a binary distinction, between mental illnesses that make people a danger to themselves, and those that make them a danger to society. A person may occupy both these positions: for example, a person with schizophrenia may be seen as both self-harming and violent towards others. A person with depression, however, may be deemed 'harmful to self', a paedophile 'harmful to society'.

> "A6:'Some of these people, they're a danger to themselves, they're not a danger to us.'"

However, as discussed above, although some people seen as mentally ill are not considered an overt danger to others, the fact that they are still classed as mentally ill, and therefore associated with those who have the potential to be violent towards others, through the unification of mental illness in social representation, makes them too seem potentially violent.

Another set of continua relates to temporal aspects within mental illness. Firstly, what proportion of time does the individual feel symptoms associated with mental illness.

Some of the time_____All of the time

Secondly, how long have they felt this way?

For a short time_____For a long time

These continua seem to be particularly important in the differentiation of different types of depression.

> "B4:'And it's also what we were talking about, if it starts running your life in a way, if, you know, you have this, not just all the time, but ...'"

> "A2:'But I'm not sure. A lot of people feel unhappy, but I think it's when it's all the time…'"

Similarly, the person can either have felt/behaved differently for a long or short time. The longer the condition continues, the more serious it is seen to be, just as the more of a person's life a condition takes up, the more serious it is.

"C3:'Believes there is no point in continuing with life - has done for some time and is thinking about doing something about it. There seems to be a temporal aspect to all of these.'" [discussing what would make each vignette seem more uncontroversially 'mental illness']

A continuum also exists regarding treatment.

Doesn't have treatment_____Has treatment

Mental illnesses that require, or are given, some form of treatment inspire more fear, especially if that treatment is drug-based.

"C1:'But the fact that you know, if you know your friend's going through a bad time and you're worried about them, then you will look after them and that doesn't scare you, but it's when it's labelled , and it's medicalised, when your problem is treated in that way, then it becomes a stigma... I mean, there's a massive difference between, it could be the same symptoms, it could be exactly the same thing, but if somebody doesn't go to the doctor it's not actually segregated as being a certain thing. And that's fine, your friend's down, you're worried about them, you look after them..'"

This echoes Jodelet's (1991) findings that foster parents were more afraid of lodgers who took medication than those who did not. Miles (1987) also found that acceptance of individuals with various diagnoses declined rapidly if it was indicated that an individual had spent time in a mental hospital. The mentally ill are seen as less mentally ill if they avoid drugs and hospitals.

There can therefore be differentiation within the same condition. Different social representations held by the public appear to exist of things that might be identically labelled by the medical profession.

Discussion

Why do we differentiate?

Why is there differentiation in social representations of mental illness? Differentiation might be a historical phenomenon: Rose (1985) states that 'neurosis' arose in the community, not in the asylum, which could explain why it is represented as less Other: it has always been among us, and not confined away from society.

However, we may differentiate in order to maintain both existing ideology and our own identity. I believe that two powerful Western ideologies are implicated in the representation of mental illness, that of the individual and that of success and failure.

In Western society today, the individual is seen as the measure of all things (Markova, Moodie et al. 1998), and the mind has become analogous to the very core of the individual (Lukes,1973). An illness that threatens the mind therefore threatens our very essence of being: to become mentally ill is to lose one's mind, and to lose one's mind it to lose one's self. Mental illness is therefore a terrifying prospect.

Similarly, great store is laid by success and failure (Ichheisser,1949). Individuals are praised for their successes and blamed for their failures. Mental illness is often seen as a failure: a failure to cope with life, a failure in the family, and so on. In order to succeed, we must therefore not succumb to mental illness, or we risk blame from our fellow members of society.

Thompson (1990) states that unification is an important mode of operation of ideology. The unification of mental illness in social representation provides a safe strategy for maintaining existing ideologies, especially those of individualism and success and failure. Within these ideologies, mental illness, and those with mental illness are discredited: the mentally ill are denied the rights accorded to others, including freedom, and voice. We need to maintain a sense of control and power over the mentally ill if we are to maintain our belief in our own rationality and rights (Porter,1987). Rose (1985) has discussed how, historically, societies have felt that degeneracy is a burden on the entire society: the 'feeble-minded' represent a weight that civilised societies find both embarrassing and irritating.

It was rare in my data to find the voice of someone who accepted the label 'mentally ill', although I did not set out to recruit participants with experience of mental illness. In order to be allowed a voice, then, the speaker must first reject the identity 'mentally ill person'4, maybe explaining why they may be erroneously thought to be.

> "B3:'But I'm not saying that I sit down and explicitly think about things. I'm just using that as an example. I'm not saying that I'm mentally ill, either, you know.' [Laughter]"

This is particularly the case in the newspaper articles I examined, which generally offered no voice to the mentally ill: some, however, were sympathetic and spoke *for* the mentally ill, a legitimate voice showing compassion for the afflicted.

> "PROZAC is a name that is too often taken in vain. This wonderful drug, which has eased the despair of millions of the mentally ill, is now usually spoken of as an unnecessary self-indulgence." 'The Daily Telegraph' 30.11.97

Similarly, the families of those referred to as mentally ill rarely speak: instead it is the 'friend', the charity worker, somebody not tainted by hereditary implication.

The occasions when voice was accorded to those connected with mental illness were usually when the person in question had now successfully rejected the label of mental illness - interviews with former sufferers, for example.

> "A view from the asylum: Anna Reynolds spent six months in a mental hospital after killing her mother. She was adjudged sane, and released. But the fate of those left behind, she says, should make us all feel ashamed" The Sunday Telegraph 12.5.96

Those who currently accepted the label of mental illness and/or were considered mentally ill by others, were largely silent (or silenced). As Hall (1991) has said, you must be positioned somewhere in order to speak: the mentally ill are accorded no such position.

Interestingly, 'The Daily Telegraph' consistently identified mental illness with ethnic minorities and young people, while 'The Mirror' associated it with young people and women. The message appears to be that an average male/white/middle-aged reader can rest safe in the knowledge that he is less at risk than 'inferior' others. Gilman (1985) maintains that insanity has long been linked with blackness or Judaism; women, as 'the weaker sex' have similarly been portrayed as more susceptible to madness (Ussher,1991).

How, then, do we reconcile all of this with the fact that mental illness is not unusual? Many focus group participants had personal experience of what could be labelled mental

---

4 This has not always been the case. Porter (1987) and Feder (1980) show how the madman has, in some historical contexts, sometimes been the only one accorded a voice. Certainly, we see in Shakespearean drama how the fool dares to speak the truth in a way others do not, and is allowed to do so by virtue of his or her insanity.

illness, in themselves or in family and friends. Newspaper articles noted how 'common' mental illness is. However to be mentally ill is clearly to be both feared and silenced. In order to speak, and to maintain a positive identity, we must therefore reject the identity of 'mentally ill person'.

Focus group participants were keen to reject the identity that could be assigned to them on the basis of information that they gave about themselves, and nervous laughter often followed certain 'admissions'.

> "B3:'Periods of unhappiness and elation, that one's interesting..... gosh, everyone could be called mentally ill. God, it makes you, it makes me worry....' [Laughter]"

> "A5:'Well, I was going to say I've suffered from every single one of these cards at some point in my life, and I'm not mentally ill.'"

Additionally, we live in a society where therapy and counselling are increasingly a part of life. Many people attend counselling, which might threaten their identity unless what they see the counsellor for can be differentiated from what a madman would see a psychiatrist for.

> "C3: 'You know, I was sitting down in the bar with some people, and we were all, there was only one of us who hadn't been to counselling, and it was like 'Well why haven't you been?' [Laughter] 'Go on, go' [Laughter].'"

> "C1:'It's almost like you've got this perception of mental illness as being really scary, and bad and a bit strange and we don't know anything about it, but on the other hand we've got this, it's perfectly acceptable to go to counselling and have therapy, about phobias and all this like really low-level stuff.'"

Conclusions

Differentiation: a way of maintaining ideology and identity

If we believe that some mental illnesses are less severe, that some forms of a mental illness are less severe than others, or that some experiences and conditions should not be classified as mental illness, then we maintain a safe identity, whilst not challenging the existing ideology. We can continue to project our fears onto the Other in the way in which Gilman (1988) and (Joffe 1999) describe. Crawford (1994) claims that health is increasingly a key area for self-expression: we need to be seen as healthy to maintain a positive identity, and therefore construct the Unhealthy Other as the risky, immoral alternative to the Healthy Self.

In differentiating, then, we can explain our own experiences, whilst maintaining the identity of the mentally ill Other as unpredictable, violent and somebody to be feared, without accepting that others may also view us in similar terms.

> "A5: 'Because when you say someone's mentally ill the first thing that comes into your head is raving spaccos dribbling in a corner defacing themselves in some way.'"

In order to avoid thus being identified with the 'raving spaccos', we must differentiate in our representations of mental illness, making some less unfamiliar than others. We do this because we cannot alter the overall ideology that presents mental illness as highly stigmatising. Differentiation, then, attempts to maintain our identity whilst not challenging this ideology.

The Problems of differentiation

Ultimately, however, this strategy of differentiation fails because it does not overcome the strength of the social representation of general, unified 'mental illness' with its central elements of violence, unpredictability and Otherness. Whilst depression, anxiety, anorexia and so forth may well be seen as more Same than Other, thereby partially convincing us that our own identity is not threatened and that existing ideology is not challenged, the fact that they can all be labelled 'mental illness' means that they will be associated with the central aspects of the general social representation, that is, violence, unpredictability and Otherness.

Mental illness and mental illnesses: cognitive polyphasia in action?

Differentiation in representations of mental illness is therefore clearly a topic that merits closer attention, and more sustained work than this small-scale preliminary study provides. It also has some interesting implications for the wider theory of social representations. Differentiation appears to be an example of cognitive polyphasia (Moscovici 1961): in a similar way to that in which participants in Wagner et al's (1999; 2000) study in Patna, India, draw on ideas from Western psychiatric thinking and more traditional forms of knowledge in their representation, participants in this study draw on aspects from the generic representation of mental illness, with its enduring and negative elements, and from more medical lines of knowledge, and in doing so, create, modify and sustain representations of *mental illness* and *mental illnesses* that interact with one another. One possibility is that the more generic representation of mental illness as unpredictable, violent, fearful and Other, has more in common with older representations of 'madness', whereas differentiated representations of mental illnesses owe more to newer ideas drawn from psychiatry and psychology, among other areas. Moscovici (1993) discusses how the theme of contagion in madness is an example of a canonic themata, an enduring element, drawn from the collective memory of a society. Perhaps this representation of generic mental illness, or madness, owes more to such notions, which continue to shape and constrain today's representations of mental illnesses.

Considering the differentiation of mental illness in representation, then, and studying its change over time, might lead to a more comprehensive understanding of the generation and development of systems of everyday knowledge and representation, and the crucial role within these processes of a dynamic polyphasic cognitive system, constantly in development (Moscovici 1961), and working against a background of historically constrained social knowledge (Rose et al, 1995).

References

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders (4th edition). Washington, American Psychiatric Association.

Appleby, L. and S. Wessley (1988). Public attitudes to mental illness: the influence of the Hungerford Massacre. Medicine, Science and the Law 28(4): 291-295.

Brockington, I. F., P. Hall, et al. (1993). The community's tolerance of the mentally ill. British Journal of Psychiatry 162: 93-99.

Crawford, R. (1994) The Boundaries of the Self and the Unhealthy Other: reflections on health, culture and AIDS. Social Science and Medicine 38(10):1347-1365

Crocetti, G. M., H. Spiro, et al. (1974). Contemporary Attitudes toward Mental Illness. Pittsburgh: University of Pittsburgh Press.

Cumming, E. and J. Cumming (1957). Closed Ranks: an experiment in mental health education. Cambridge, Mass.: Harvard University Press.

Davison, G. C. and J. M. Neale (1994). Abnormal Psychology (6th edition). New York: John Wiley and Sons Ltd.

De Rosa, A. S. (1987). The social representations of mental illness in children and adults. In W. Doise and S. Moscovici (Ed.s) Current Issues in Social Psychology.. Cambridge, Cambridge University Press.

Duveen, G. and B. Lloyd (1990). Introduction. In G. Duveen and B. Lloyd Social Representations and the Development of Knowledge (pp. 1-9). Cambridge: Cambridge University Press.

Farr, R. M. (1993). Theory and method in the study of social representations. In D. Canter and G. Breakwell (Eds) Empirical Approaches to Social Representations. Oxford: Clarendon Press.

Feder, L. (1980) Madness in Literature. Princetown: Princetown University Press.

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

Foucault, M. (1961/1995). Madness and Civilisation. London: Routlege.

Furnham, A. (1984). Lay conceptions of neuroticism. Personality and Individual Differences 5(1): 95-103.

Furnham, A. and J. Rees (1988). Lay theories of schizophrenia. International Journal of Social Psychiatry 34(3): 212-220.

Gelder, M. (1983). Oxford Textbook of Psychiatry. Oxford: Oxford Medical Publications.

Gilman, S. L. (1985) Difference and Pathology: stereotypes of sexuality, race and madness. New York: Cornell University Press.

Gilman, S. L. (1988). Disease and Representation: images of illness from madness to AIDS. Ithaca: Cornell University Press.

Goffman, E. (1968). Stigma: notes on the management of spoiled identity. Englewood Cliffs: New Jersey, Prentice Hall

Hall, P., I. F. Brockington, et al. (1993). A comparison of responses to the mentally ill in two communities. British Journal of Psychiatry 162: 99-108.

Hall, S. (1991). Old and new identities, old and new ethnicities. In A. D. King (Ed) Culture, Globalisation and the World System. New York, Macmillan.

Ichheisser, G. (1949). Misunderstandings in human relations: a study in false social perception. American Journal of Sociology LV: 1-72

Jodelet, D. (1991). Madness and Social Representations. Hemel Hempstead: Harvester Wheatsheaf.

Joffe, H. (1995). Social representations of AIDS: towards encompassing issues of power. Papers on Social Representations 4(1): 29-40.

Joffe, H. (1996). 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.

Johannsen, W. J. (1969). Attitudes toward mental patients: a review of the empirical research. Mental Hygiene 49: 218-228.

Jovchelovitch, S. (1997). Peripheral communities and the transformation of social representations: queries on power and recognition. Social Psychological Review 1(1): 16-26.

Leventhal, H. and Benyamini, Y. (1997) Lay Beliefs about health and illness. In Baum, A. Newman, S., Weinman, J., West, R. and McManus, C. (Eds) Cambridge Handbook of Psychology, Health and Medicine. Cambridge: Cambridge University Press.

Livingstone, S. and P. Lunt (1996). Rethinking the focus group in media and communications research. Journal of Communication 46(2): 79-99.

Lukes, S. (1973) Individualism. Oxford: Blackwell

Maclean, U. (1969). Community attitudes to the mentally ill in Edinburgh. British Journal of Preventative and Social Medicine 23: 45-52.

Markova, I., E. Moodie, et al. (1998). Social representations of the individual in a post-communist perspective. European Journal of Social Psychology 28(5): 797-830.

Matheson, J. and J. Pullinger (Eds.) (1999) Social Trends 29. London: The Stationery Office.

Miles, A. (1987). The Mentally Ill in Society. Oxford: Blackwell.

Morant, N. J. (1995). What is mental illness? Social representations of mental illness among British and French mental health professionals. Papers on Social Representations 4(1): 41-52.

Morant, N. J. (1996). Social Representations of Mental Illness: a study of British and French Mental Health Professionals. Unpublished PhD thesis, University of London, London.

Morant, N. J. (1998) The social representations of mental ill-health in communities of mental health practitionners in the UK and France. Social Science Information 37(4): 663-685.

MORI (1979). Public Attitudes to Mental Illness: research study conducted for the Mental Health Appeal. London: MORI.

Moscovici, S. (1963). Attitudes and Opinions. Annual Review of Psychology: 231-260.

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

Moscovici, S. (1993) Introductory Address. Papers on Social Representations 2: 160-170

Nunnally, J. C. (1961). Popular Conceptions of Mental Illness: their development and change. New York: Holt, Rinehart and Winston.

Porter, R. (1987) A Social History of Madness. London: Weidenfeld and Nicholson.

Räty, H. (1990). A world without mental illness: concepts of mental health and mental illness among a student group. Social Behaviour 5(5): 315-326.

Rabkin, J. (1974). Public attitudes toward mental illness: a review of the literature. Schizophrenia Bulletin 10: 9-33.

Rabkin, J. G. (1972). Opinions about mental illness: a review of the literature. Psychological Bulletin 77(3): 153-171.

Rippere, V. (1977). Common sense beliefs about depression and anti-depressive behaviour: a study of social consensus. Behaviour, Research and Therapy 15: 465-473.

Rippere, V. (1981). How depressing: another cognitive dimension of common sense knowledge. Behaviour, Research and Therapy 19: 169-181.

Rose, D., Efraim, D., Gervais, M.-C., Joffe, H., Jovchelovitch, S. & Morant, N.(1995) Questioning consensus in social representation theory. Papers on Social Representations 4: 150-156

Rose, D. (1996). Representations of Madness on British Television: a social psychological analysis. Unpublished PhD thesis. University of London, London.

Rose, D. (1998) Television, madness and community care. Journal of Community and Applied Psychology 8:213-228.

Rose, N. (1985). The Psychological Complex. London: Routledge.

Sarbin, T. and J. Mancuso (1970). Failure of a moral enterprise: attitudes of the public toward mental illness. Journal of Consulting and Clinical Psychology 35(2): 159-173.

Sontag, S. (1978). Illness as metaphor. New York: Farrar, Straus and Giroux.

Stockdale, J. and S. C. Purkhardt (1993). Multi-dimensional scaling as a technique for the exploration and description of a social representation. In . D. Canter and G. Breakwell (Ed.s) Empirical Approaches to Social Representations. Oxford: Clarendon Press.

Thompson, J. B. (1990) Ideology and Modern Culture. Cambridge: Polity Press.

Ussher, J. (1991) Women's madness: misogyny or mental illness?. Hemel Hempstead: Harvester-Wheatsheaf

Wagner, W. (1994). Fields of research and socio-gensis of representations: a discussion of criteria and diagnostics. Social Science Information 33(2): 199-228.

Wagner, W., Duveen, G., Themel, M. & Verma, J. (1999). The modernisation of tradition: Thinking about madness in Patna, India. Culture and Psychology, 5, 413-446.

Wagner, W., Duveen, G., Verma, J. & Themel, M. (2000)."I have some faith and at the same time I don't believe in it" - Cognitive polyphasia and culture change. Journal of Community and Applied Social Psychology, 10, 102-314.

World Health Organisation, (1993). The ICD10 Classification of Mental and Behavioural Diagnostic Criteria for Research. Geneva: World Health Organisation.

Zani, B. (1993). Social representations of mental illness: lay and professional perspectives. In D. Canter and G. Breakwell (Ed.s) Empirical Approaches to Social Representations. Oxford: Clarendon Press.

Appendix 1: Topic Guide

- What is the first thing that comes into your mind when I mention mental illness?
- What is mental illness? Are there any other names for it? What do you think is the best name for it?
- What do you think are the causes of mental illness?
- What are the effects of mental illness? (On the person suffering and on those around them; social/ physical/ psychological).
- Can mental illness be cured?
- INTRODUCE CARDS.
  - Which, if any of these people do you think might be mentally ill?
  - What do you think might have caused them to be like this?
  - What do you think they are like? What might it be like talking to them? How might they behave? How might you feel about being with them?
  - What do you think might happen to them
- Does anybody else have anything that they would like to add about any of these issues?

Appendix 2: Vignettes used in focus groups

Feels very unhappy and hopeless.
Sometimes hears voices.
Very underweight. Eats very little.
Believes there is no point in continuing with life.
Has periods of unhappiness and periods of elation.
Performs protective rituals.
Believes that people are talking about them behind their back.
Sometimes has strong feeling that can't breathe and is dying.