AN INVESTIGATION OF A CONSTRUCTIVIST APPROACH

TO SELF-DISCOVERY IN COMMUNITY MENTAL HEALTH CARE

A Thesis Presented

by

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SUMMARY

A constructivist approach is found by identifying its cross-disciplinary roots in prior research. The theoretical connections are an exposition of personal and moral issues in a science of human services. Self-discovery emerges as an alternative focus to institutionalised care for a first-year cohort in the planned closure of a psychiatric hospital.

The development of three educational courses as the investigation progresses provide (i) an extract of the methodology, (ii) a demonstration of the heuristic nature of the research, and (iii) the utility of an industry and university collaboration in doctoral study. Because they are products of the research, the curricula provide no data as yet, but incorporate much of what was learnt during the course of the research.
Three staff-supported residential settings provide the basis for an empirical study of a constructivist approach to self-discovery. The fieldwork is a video-taped record of triangulated data collection in the houses, the evidence for each of which is individually presented in narrative format. The data is a tapestry of multiple realities that decentres individual construing while demonstrating a will to know.

The study provides guidelines (i) in the use of a constructivist approach to connect the centre with the periphery of a mental health service, (ii) for a unifying basis in multi-professional working, and (iii) for an empowering mechanism of personal support to replicate good practice in psychotherapeutic work.
ACKNOWLEDGEMENTS

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PROLOGUE

Many countries have created institutions to care for people who have a mental illness. Where this was once the norm, new community services are now developing (The Centre on Human Policy, 1988). In Britain, the National Association for Mental Health (MIND) has called for the closure, during the 1990s, of the remaining 100 Victorian mental hospitals, where 60,000 people continue to live (Hepplewhite, 1990).

Of 100,000 mental patients discharged since 1970, only 4,000 received a local authority residential place to live (Groves, 1990). People who have been in mental hospital need the help of others in order to do more for themselves and to be fully engaged members of communities, neighbourhoods and the wider society (Cullen, 1990). Current legislation (Secretaries of State for Health, Social Security, Wales, and Scotland, 1989) and government policy (Department of Health, 1989) stipulate that staff support in the community must be assured for discharged people.
Research in this field has followed professional 'lines', with studies reflecting multi-professional interests, e.g. of psychiatrists, psychologists, philosophers, and sociologists. Serious doubts have been raised about the meaning and warrant for the claims of such research (Lakoff, 1987; Bernstein, 1988; Bloch and Harari, 1990). The present study questions methodologies that appear to segregate the professional disciplines operating in the field of mental health.

The research moves beyond the main corpus of previous research, i.e. upon patients clinical conditions in the transition before or after discharge and upon their social problems, e.g. of adaptation away from the hospital. It attempts to move beyond the 'high hard grounds' of professional knowledge to the 'swampy lowlands' where the every day, messy, confusing problems often defy solutions by traditional types of knowledge (Schon, 1987).
Long-term institutional life has been found to be impersonal and unstimulating. Such qualities of life in mental hospital were instrumental in deciding strategies to end long-term hospitalisation for people with a history of mental illness. In contrast to the impersonal, institutional, or clinical effects for people who use and work in mental health services, a constructivist approach to self-discovery is intended to increase knowledge and understanding of life and work in the community.

Excluding the number of hospitalized patients and those who use psychiatric out-patient and day services, the people leaving hospital enter a United Kingdom where six million individuals suffer from mental illness in the course of a year -- representing one in 10 of the population (The Mental Health Foundation, 1990). Identified by family doctors (GPs), according to criteria of the International Classification of Diseases, the whole community population of sufferers indicates a potential public health interest in the analogies raised by this study, e.g. self-sufficiency in contrast to dependency, self-discovered knowledge in contrast to received knowledge, integration in contrast to alienation.
CHAPTER ONE

THE LITERATURE REVIEW

The Summary and Prologue raise an issue about the state and conduct of research science, in the context of transition from institutional to community-based care. The first two chapters of the thesis are a set in examining the issue—an objective analysis, followed by a subjective reflection of knowledge and experience in the field.

The literature review is a cross-disciplinary investigation that is focussed upon methodology, from the self-discovery perspective.

The review is also subject to the influence of the researcher's educational role, referred to in the Summary. The investigation, whilst not denying 'clinical' interests in the field, embarks upon a broader-than-clinical perspective.
A cross-disciplinary, multi-national approach to the literature will include contributions from philosophy, sociology, education, psychiatry, psychology, and nursing. A broad-brush approach to the literature will be sharpened in focus by the investigation of a constructivist approach to self-discovery.

An examination of alternatives to hospital care, research into the effects of mental disorder, and long-term studies of discharged patients, will be followed by an analysis of evaluative methods to determine quality of care and by reviewing the educational transition to community care.

Alternatives to Hospital Care

The rationale to put people in mental hospitals, and more recently to take them out, is not based on research results (Hoult, 1986). Although socio-economic and political influences that surround the present research are outside of the focus of examination, these forces form a backcloth to the study. Therefore, a brief review now will provide a macro-frame of reference around the context of the present research, while Chapter Two will establish hospital and community baselines in the study.
The United States and Italy are examples of the modern trend that was referred to in the Prologue, to 'close' institutional care for the mentally ill. In these countries, the 'closure' of mental hospitals coincided with a period of social reform based upon equal opportunity and individualism, e.g. emergence of civil rights, divorce reforms, workers rights, and the decline in hospital populations followed the discovery of psychopharmacological agents for the treatment of symptoms of mental illness (Mosher, 1985; Wilson, 1986).

The Italian experience in particular was distinct from the British movement for voluntary treatment under the 1930 Mental Treatment Act or informal treatment under the 1959 Mental Health Act, or the open door movement of the 1950s (Jones and Poletti, 1986). In this case, research found that admissions to hospital had stopped, rather than hospitals being closed:

When the Trieste team say 'We closed the mental hospital', they do not mean 'We closed the mental hospital. 'They mean 'We broke the power of the mental hospital over the patients.'

(Jones and Poletti, 1986, p. 149)
In America, the 'near revolution' in the health and social services landscape was characterized by five primary hallmarks of change:

decentralization of services, diminution of the segregation of social services clients, reduction in the role played by large congregate care facilities, reinstatement of local control over service delivery, and -- as a means of accomplishing the above ends -- a dramatic expansion in the use of the private sector to provide social services.

(Bradley, 1984, p. 1)

Among these wider scenarios of influence, McKnight (1977) postulates three professional assumptions regarding need and three professional assumptions regarding the remedy of need:

First is the translation of need into deficiency; the second disabling characteristic of professionalized definitions of need is the professional practice of placing the perceived deficiency in the client; the third disabling effect results from specialization -- the major 'product' of advanced systems of technique and technology. The first assumptions about a remedy for the need is that I the professionalized servicer, am the answer; a second disabling characteristic of professionalized remedial assumptions is the necessity for the remedy to define the need; and the third disabling remedial practice is the coding of the problem and the solution into languages that are incomprehensible to citizens.

(McKnight, 1987)
Thus, the alternatives to hospitalization become polarized, and ultimately methods for research reflect the choices about alternatives that underlie professional decisions. However, two distinct alternatives have emerged in North America. The medical alternative to hospital treatment is one common response to hospital closure (Stein and Test, 1980). A less common but distinct response is the focus upon normalization (Wolfensberger, 1972) and accomplishments that services achieve for people in the community (O'Brien and Lyle, 1987). Normalization implies that it is a person's role in society which ought to be valued. However, it cannot be denied that in Western Society it is those who are rich, powerful and attractive who are valued (Cullen, 1990).

Professional, service, and personal ideologies interact with practical interventions in mental health care. This is evident from the review thus far. Different constructions are applied to intervention, as the result of this pluralism of beliefs and values. Bernstein (1988) raises the question of whether ideological bias in research can be bracketed, on the path to developing 'a genuine science of individuals in society' (p. 27).
Early research indicates on the one hand that hospital treatment is superior to the community alternatives for the average patient (Braun et al., 1981; Keisler, 1982). Recent British research (Knapp et al., 1990) contradicts this. Better outcomes in the community appear to depend on comprehensive and continuous programmes which are not available in the hospital setting; thus, the comparative findings become invalid.

Further, the groundrules for 'replication' studies need to be checked. For example, Hoult's (1986) study in Australia changed Stein and Test's age criteria from 18-23 to 15-65. Hoult's researchers also switched from the American principle of assertive daily tracking of patients to a focus on assertive training, in hygiene and grooming, for example. Levels of medication used in the control and experimental groups were not reported in either study. When I visited Stein and Test's team in the U.S.A., as part of my literature search in 1988, I found that medication had been used more frequently and in higher initial doses after assessment in the community than in hospital.
Normalization is the basis of a citizen-based approach to mental health care in Ontario, Canada, and northeastern states of America (Chamberlin, 1979; Church, 1986; Specht and Nagy, 1986). The guiding principle, in contrast to assertive professional treatment based upon individual tracking, is focussed upon the individual in the community. The premise is that many issues today in the lives of ex-patients living in the community can only partially be addressed through a professional response. These issues are identified as a need for closeness to ordinary people in typical situations and experiences, the need to have a place in the lives of others, and a need for security, stability, and order in one's life, and control over personal decisions (Massachusetts Department of Mental Health, 1988).

The significant differences between the two alternative approaches to hospitalisation are the research methods they use, their approaches to employment and consumer rights, and staff development. Common elements are a longitudinal view of an identified priority population and a preference for individualised community care over inpatient
treatment. The most striking difference, reported by an independent evaluator (Hogan, 1987) describes the Stein and Test (1980) approach as:

candidly assertive to the point of being consciously controlling of certain aspects of client lives, in the interest of treatment effectiveness. Its educational system leads to a high profile for clinical change agent training in psychiatry and social work. Training for direct-care staff is problematic although senior clinicians conduct on-the-job seminars.

(Hogan, 1987)

In contrast, Hogan (1987) reports that the normalization approach includes stringent prohibitions against coerced treatment, and for mandated client participation in program planning activities. There has been a high profile toward training of direct-care staff. A particular feature of this strategy is that the bulk of training resources has been invested in value clarification and promotion of positive values related to the mission of community mental health care.

The latter approach applies research design that is exploratory, qualitative, descriptive, or multiple methods of data collection. In contrast, the formal
model, known as PACT (Program of Assertive Community Treatment) uses the protocols of traditional research methodology.

These prototype, alternative approaches to hospitalization demonstrate how the use of knowledge can determine different outcomes. More specifically, they indicate what kind of knowledge can be used to determine particular changes, e.g. the use of consumers' views and participation to clarify the values and purpose of the service. Both rely on academic or occasional on-the-job training, for the preparation and development of staff.

A third alternative identified by Wilson (1986) is the self-help groups approach: "a direct response to the lack of relevant services offered by professional systems, or as a model of consumer participation within service delivery systems" (p. 19). Wilson (1986) traced this approach to the founding of the Jesuit Order in the mid-1500s, to the Protestant Groups that emerged after the Reformation, to the Friendly Societies of England in the nineteenth century, and to the growth of extrafamilial groups during the American Industrial Revolution. The developmental assumption inherent in this and the
normalization approach forms an alliance against the position that people with mental problems cannot improve without professional intervention.

The British experience is informed by historical antecedents. The point of significance is the relative absence of a genesis in history at the level of human science, i.e. a microscopic focus upon the person and their contribution to care. Much of the negative view of institutions has been encouraged by their dominant features and by the process of generalisation that have taken little account of variation between them (Sinclair, 1988). However, The Independent Review of Residential Care in the 1980s (Wagner, 1988) found four major areas of concern in alternatives to hospital care: lack of preparation, lack of accommodation, lack of social contact, and lack of progress (pp. 213-214).

The Effects of Mental Disorder

Use of language by the mentally ill and the categories of psychiatric illness (Spitzer and Williams, 1987) have been prominent research criteria in the mental health field (Hirsch and Leff, 1975; Halliday, 1978; Rosenberg, 1979; Sacks, 1979; Heath, 1986). The
literature is weighted towards a concern with mental
disability and its correction. Mental patients have
been described as being socially inarticulate and
their language incorrect (Coulter, 1973; Andreasen,
1979; Ragin and Oltmans, 1983; Menuck and
Seeman, 1985). However, investigators of language
(Bartsch and Vennemann, 1975) and pathology (Epstein
and Lieff, 1986) suggest that phenomena will be
reinterpreted in the light of cross-disciplinary
advances. Yet, these studies indicate that any change
in thinking by researchers would be accompanied by
methods grounded in the criteria of illness. The
trend of research in this field can be seen to be
academic and psychiatric (Werner and Kaplan,
1963; Kasanin, 1964; Hirsch and Leff, 1975; Rosenberg,
1979).

Healy (1990) argues that the obvious property in
question is the property of life, not a chemical
property, for example. And the implications of
entering life into professional or academic equations
is that personal meanings can be introjected with the
artefacts of strangers.

Berger and Bracac (1982) and Halliday (1978) argued
that to focus on language or schizophrenia as a
phenomena is likely to misconstrue a balanced explanation of what researchers find. According to investigators who research 'beneath' language to examine individual meaning (Chapman, Twite, and Swann, 1979; Griffith, 1981; Beeman, 1985; Wells, 1985), epistemology and phenomenology become detached from a theoretical continuum which had assumed certain knowledge and events as the two end points.

The propensity to validate data is questioned further in examinations by philosophers. Polanyi's (1958) view is that "The most pregnant carriers of meanings are the words of a language...we are aware of them only in a subsidiary manner" (p. 57). Lecercle (1985) also refers to two languages. One is social communication, where a speaker dominates surface language. The other language comes from "the depths of the body, where the articulate word becomes a scream, where only affects and passions of the body can be expressed" (p. 31). That the source of personal knowledge has its roots in the subsidiary awareness of our body as merged in our focal awareness of external objects, reveals not only a logical structure of personal knowledge but also its dynamic
sources: an external thing is given meaning by being made to form an extension of ourselves (Polanyi, 1958, p.60).

Formal definitions of what it means to do professional work can avoid a definitive understanding by the person relying on the service that is provided. If the practical interpretations of a definition must rely on its undefined understanding by a person, definitions could, in Polanyi's (1958) terms, reduce personal meanings but never eliminate them (p. 250). Rose and Black (1985) argue that professional practice in mental health care obscures meaning because it is 'closed-ended:

The world, the present, the future are circumscribed by a disease entity which begins with assumptions about symptoms, extends to remission, and concludes with decompensation...there is nowhere to go for a patient/ex-patient with these end-points.

(Rose and Black, 1985, p. 44)

The inclusion of a broader-than-clinical perspective in the literature of mental disorder, i.e. the study of personal knowledge and meaning, demonstrates another dimension, or depth, to the investigation of psychiatric effects. There would seem to be no
diminution of the effects of mental disorder by broadening the perspective. Indeed, the dominant view of contemporary education holds that questions of practice are hybrid, insofar as they involve a crossing of value-judgements with different forms of empirical inquiry (Whitehead, 1981). A constructivist approach to research examines these crossings and forms.

Within psychiatry, the assessment of negative symptoms raises 'serious questions about the validity and reliability of instruments in use at present':

Many rating scales have been developed, but the plethora of instruments, and the vast differences between them highlights the lack of agreement among experts as to the best method of evaluation.

(Leach, 1991)

Long-Term Studies of Patients Discharged into the Community

Longitudinal research has evaluated schizophrenic patients discharged from mental hospitals into community care (Harding, 1985; Harding et al., 1987a, b). Harding reports that constructs such as outcome and end state often lead to erroneous conclusions about disorders. Bleuler and other
Europeans describe plateau states of five years in which subjects have achieved a certain level of recovery and a stabilized period (Bleuler, 1979). Specifically, "such words end up being interpreted by clinicians and patients alike as real phenomenon" (Harding, 1986).

A pervasive problem in the psychiatric literature is recovery. What is known about recovery is known and applied by a stranger to a person who has yet to recover: when you have a 'breakdown', your biography is impregnated by a clinical paradigm with an impersonal history. The patient has something wrong—not, in most cases, a broken bit to be fixed, but an unacceptable state of knowing and acting. It is measured against theoretical constructs evolved by the current state of the art in mental science and individually interpreted by the investigator.

Bleuler (1979) had cautioned that, when considering a subject as having a life, we then must focus on the person behind the disorder. The top rating for a
standard assessment tool (GAS 91-100) in psychiatric research, using the following criteria, is:

No symptoms, superior functioning in a wide range of activities, life's problems never seem to get out of hand, and is sought out by others because of his warmth and integrity.

(Endicott et al., 1976, p. 769)

Harding's research is one of five recent long-term studies, averaging 30 years, with an average sample size across the studies of 260. They were conducted in Vermont (Harding et al., 1987a,b) and Iowa (Tsuang et al., 1979), in Zurich (Bleuler, 1979), in Bonn (Huber et al., 1979), and in Lausanne (Ciompi and Miller, 1976). Bleuler's study was the first to follow patients out of hospital into the community. Although Harding's study was the smallest sample, it is regarded as the longest because it acquired patients histories after recovery of 22-62 years post first admission. Other studies looked at five-, ten-, twenty-, and thirty-five years post first admission. Harding regards all of the studies, including her own, as outcome studies that are "research artifacts; that
one investigator's 'outcome' is another investigator's 'course' -- an investigator's device:

We joke about the fact that no one we know as colleagues, including ourselves, could meet the GAS score of 91 to 100, yet we persist in using this scale and others as earnest assessments of subjects."

(Harding, 1986, p. 203)

Richardson's (1987) study of mental patients' seclusion-room experience also found that different constructs share a similar meaning. Subjects described situations leading up to seclusion, but staff described aggressive behaviour justifying seclusion (p. 237). Yet, almost all reasons provided by both groups involved subjects out-of-control impulses or problems in relationships. Both Harding and Richardson wanted to know more about what is being said to people and what it means to them, and how this data throws light on the outcome of a study.

The longitudinal researchers used up to 15 so-called classic instruments, including a reconstruction (Leighton and Leighton, 1949) of the Meyerian Life Chart (Meyer, 1919), to document patterns, shifts, and trends in the course of life for members of their cohort. Despite using different diagnostic systems
for determining schizophrenia, varying lengths of follow-up and methodology, the similarity of their findings is remarkable. Fifty-five percent of 1303 patients, followed over two to three decades, had experienced significant improvement or recovery (Harding, Zubin, and Strauss, 1987). Homogeneity of findings occurred across a wide range of traditional methodology, logistics unique to each study, and across international cultures. The principal deficit of these studies is the utility of their outcomes: what is the use of research that says 'Half the people will get better and half won't; we don't know who will be a part of either half, or why, but on the basis of all this work we think it will be more-or-less a 50-50 proposition.'

Thirty-five years on since the mid-1950s, long-term investigation reflects a difficulty with unchanging methodology in a field of significant contextual change, i.e. the transition from hospital to community-based care. Least of these significates, it would appear, is adapting methodology to changes in the
service-user population. That is to what extent can the service user's knowledge or personal growth contribute to research outcomes, and the deficits in its design and methodology? Implicit in the methodological problems is a need to try and allow the subject 'in', as a research participant. This point is underscored by evidence in these studies that 'significant improvement or recovery' entails 5-10 years of time, as a minimum period, albeit for unknown reasons, for half a sample.

Traditionally, investigators seeking to resolve or understand mental problems use research methods that value psychiatric diagnostic criteria; these focus on concepts of etiology, an evolving course of disorder, underlying vulnerability, limits of stimulation, or resolution of conflicts (Spitzer and Williams, 1987). However, a number of recent alternative studies in Britain, demonstrate a clinical approach to treatment and care that involve the patient's personal constructs (Bannister and Fransella, 1986; Dunnett, 1988; Kenny, 1988; Mair, 1988; Winter, 1988; Watts, 1988; Norman and Parker, 1990).
A non-clinical corollary to this work is demonstrated in an educational context (Pope, Watts, and Gilbert, 1983; Pope and Denicolo, 1986, 1989).

The widening perspective of research focus indicates different ways that the effects of professional knowledge can be applied to the lives of people who are research subjects. Given the long-term hospitalization of mental patients in the present study, the manner of their investigation, in view of the literature, may be important to their life chances for being independent of a mental health service or important to the quality of service provision.

The literature raises the methodological question of the extent to which recovery is an undue burden, both to the subject and the research. What research effect arises when a person seen to be schizophrenic, for example, is also deemed to require a recovery from schizophrenia? Is it a false science that recognizes schizophrenia in methodology that derives from a cross-disciplinary study of prior research? The
dimension-addition to literature of personal construct
theory (Kelly, 1955; Thomas and Harri-Augstein, 1985)
is consistent with the expanded focus, beyond a
'medical' alternative, of normal living and self help
as practical alternatives to hospital care. A
theoretical and practical alternative paradigm offers
the potential for independent investigation of both
the alternative and prior research.

Measuring Quality of Care and Life Outcomes

In contrast to the 15 classic scales and schedules
cited above, used in long-term outcome studies,
Bersani (1988) identified 44 instruments used in
mental health services. Thirteen of these are used to
measure the integration of individuals in the
community and 31 are used to measure the quality of
residential care. Of the 13 instruments, two are
applied specifically to people who use mental health
services and one of those is also cited as a
residential evaluation tool.
There is a distinct difference between the reason for using a research instrument in a long-term outcome study (e.g., the five long-term studies) and quality of care evaluation. Harding and others (1987a,b) and Harding, Zubin, and Strauss (1987) referred to the difference as the difference between producing replicable research artifacts and producing non-replicable data that was meaningful and useful because of its individuality.

Homogeneity of findings would be impossible if the differences in individual evidence were maintained as data was processed. Methodological problems (Table 1) of long-term follow-up studies would be overcome, but it would be incredulous to suppose, given the literature thus far, that professional disciplines, working in isolation with traditional approaches to research, would be confident with methodological experimentation.
Table 1. Some methodological problems in long-term studies that make comparisons difficult (Harding, Zubin, and Strauss, 1987)

a) Different samples selected because of different diagnostic criteria.

b) 'Schizophrenia' often not defined.

c) Different length of follow-up periods.

d) Outcome often defined only as 'recovered' or 'unrecovered'.

e) Varying sources of follow-up data (that is, case records versus actual interview).

f) Lack of blind data collection procedures (that is, the investigators knew the previous history of the subjects).

g) Use of clinical nonstructured interviews.

h) Single cross-sectional assessments.

i) Too many missing or deceased subjects.

(Harding, Zubin and Strauss, 1987)

An earlier American study by Bradley (1984) reported that because the expansion of mental health services outpaced the development of support systems, there was a tendency to chose methods that would police the system rather than provide an overview structure and enhance quality. There is a further comparison of formal methodological interventions, as a part of professional enquiry, as well as mediated and normative methods, in the context of community initiatives using educational means (Table 2).
<table>
<thead>
<tr>
<th>Example</th>
<th>Normative</th>
<th>Mediated</th>
<th>Formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring and evaluation</td>
<td>Calling or visiting family member or friends to see how things are going in their life.</td>
<td>Citizen Monitoring Project</td>
<td>Quality Assurance, Citizen Monitoring Project.</td>
</tr>
<tr>
<td>Research and study</td>
<td>Use of library to learn more about organising parents groups, locating appropriate services, causes of a disabling condition, etc.</td>
<td>Families research how their school system could be more integrated.</td>
<td>Business people get together as sub-committee of Chamber of Commerce to study inclusion of people with mental health problems.</td>
</tr>
<tr>
<td>Friendship</td>
<td>Natural spontaneous friendships.</td>
<td>Introducing and supporting a friendship not part of a formal program.</td>
<td>Citizen Advocacy.</td>
</tr>
<tr>
<td>Hospitality</td>
<td>&quot;Hospitality Committee&quot; at church to welcome new members, or ensure that people who are alone have a place to go during holidays.</td>
<td>&quot;Neighborhood Networks Program&quot; which works with neighbors of a community residence.</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Sharing between people who've been through certain experiences about what did/didn't work. Positively interpreting people with disabilities in a group situation.</td>
<td>Working on a project to integrate a disabled person into a group or organization.</td>
<td></td>
</tr>
<tr>
<td>Practical assistance</td>
<td>Group gets together to help mentally ill person renovate apartment. An individual offers a ride to church to another person.</td>
<td>Voluntary neighborhood program to assist elderly people with chores.</td>
<td>Church buys a van and picks up people.</td>
</tr>
</tbody>
</table>

*Table 2. Selected examples of community initiatives*  
*(Massachusetts Department of Mental Health, 1988)*
The American studies, preceding the transition to community care in Britain, provide telling evidence about the challenge to investigative methods as well as personal care in new community-based mental health services.

Bradley's (1984) five-year project, involving three research institutes in the United States, demonstrates a similarity between the research anomalies noted by Harding (1986; 1987a,b). Bradley and colleagues found that methods to evaluate quality in human services were 'one-sided in character':

> The imbalance stems from an over-reliance on mechanisms that are static, that fail to reward superior performance, that entail burdensome documentation requirements, and that are oriented to fault-finding rather than capacity enhancement.

(Bradley, 1984, p. 10)

Bradley described a tendency for evaluative methods to be reactive rather than positive, or proactive. She found that proactive mechanisms are by nature positive and forward looking, while reactive mechanisms are 'generally negative and targeted to past practice.' The latter are characterised by a fault-finding, corrective approach to investigation. Quality of care measures are significant in the literature in terms of
their discrete reliance on values which conflict with the values inherent in the methodology of psychiatric research.

Bradley (1984) identified eight methods that were used in 22 mental health services across the United States. The methods were described as pre-screening and self-assessment; outcome monitoring and evaluation; case tracking and exception reporting, client surveys, observation, performance contracting, training, and consumer empowerment (pp. 110-185). A companion study examined 51 cases of citizen evaluation in practice (Bradley et al., 1984). Ten research methods identified in this study were public forums; interviews of service providers, key informants, clients; records audit (secondary data analysis) of services, clients, facilities; site visits; community surveys; observation; structured small group evaluation (of available data); case simulation (posing as clients); use of standardized instruments (Wolfensberger and Glenn, 1975); freedom (access to) of information.

These studies point to the influence of ideology on scientific, or objective, knowledge, and empirical, or personal, knowledge. Mayer (1978), in discussing the
position of ideology in social and institutional change, characterizes ideology as follows:

Ideology is (1) a set of values that is (2) a property of an organization (3) designed to influence the acts of others regarding (4) the goals of the organization and (5) the appropriate means for pursuing these goals...We are assuming that an ideology deals primarily with output (outcome) goals, by which other types of goals must be justified.

(Mayer, 1978, p. 14)

If the ideology relates to the sort of meaning that is essential to a quality explanation, the literature also suggests that values would then determine the kind of research method needed for the valued outcome. For example, methods used for measuring the quality of a service are of a different sort than the methods used for measuring levels of psychopathology. Ideology, as a knowledge base, would, therefore, direct the researcher to a different range of questions than would psychiatry, as a knowledge base.

The acknowledgement of a values system which underlies the choice of research methods is also made by Bersani (1988). The values hallmark of the service quality in this mental health literature is based on the assumption of continuing human development despite the
constraints of disability. For example, Harding et al. (1987b), in the 20-year follow-up of severely disabled hospital patients, found that "widely heterogeneous patterns of social, occupational and psychological functioning evolved over time" (p. 732), and they concurred with Vaillant (1978) that "diagnosis and prognosis should be treated as different dimensions" (p. 733). This principal hallmark contrasts with values in research methods which assume that recovery from mental illness is not necessarily a life-long, degenerative process that progresses in a predictable, linear pattern (Wilson, 1988).

Gubman and Tessler (1987), while not identifying the literature, said that methods which incorporate personal insights lack a conceptual framework within which they might be usefully grounded and integrated. This literature review begins to fill-in that gap, by searching for a constructivist approach with a personal paradigm of enquiry. Their search of the social science literature, as they put it, revealed (the) three 'relevant themes': first, studies of
mental illness that view family interaction and communication as the causal agent; second, studies which view families as agents of rehabilitation, where the focus is on preventing patient relapse; third, studies which emphasize families as bearers of burden. In the tradition of the psychiatric studies referred to, Gubman and Tessler (1987) "apply an illness behaviour perspective to the study of family burden, hoping to explain a variety of problems that typify families with mentally ill members" (p. 228). Thus, the values inherent in the research method seek an explanation based upon the assumptions of illness behaviour.

As the result of quality assurance and evaluation studies, and the effect of hospital versus community-based treatment studies, there is a shift from a model of viewing mental illness as either acute or chronic to a model in which any person is seen as being able to overcome the negative effects of the disability if given appropriate support (Wilson, 1988). Despite this shift, the literature indicates a
polarisation of the respective methodologies, which drive and nourish the studies. The use of client outcomes to measure service quality and effectiveness represents a shift in philosophy. This is demonstrated in the differences between client indicators such as employment status, income, living situation, social activities and networks, leisure time activity, satisfaction with life, to clinical indices such as recidivism, mental health services use, medication use, and degree of symptomatology. Despite a shift to new values and new indicators, research methods continue to measure service-related indicators. Wilson (1988) postulates that they are easier for researchers and service providers to use and understand than are the 'soft' indicators that reflect quality of life; secondly, quality of life criteria are viewed as predictor variables for treatment-oriented outcomes rather than as important outcomes in their own right; thirdly, no consensus has emerged about the goal of community support services. Thus, the service system and methods used for research are considered to be important in maintaining people in community services, rather than assisting them whenever needed to achieve or maintain roles as regular community members.
In an extensive review of outcome research in the 1980s, Wilson (1988) recommended that we think about outcome research as follows:

a) Mental illness is not necessarily a life-long degenerative process that progresses in a predictable, linear pattern;

b) People with severe mental illness can maintain jobs, housing and positive relationships with friends and families regardless of the presence of psychiatric symptoms, and with various levels of mental health support;

c) Mental health services must be designed to be flexible and responsive to different individuals' needs within any given environmental context;

d) People with mental illness can and should have a choice about the type and intensity of services they receive;

e) Most people with mental illness do not view themselves as chronic mental patients, and they value independence and productivity more highly than any other treatment outcome or aspect of life.

(Wilson, 1988, p. 6-7)

Here, the transition to community-based care has coincided with a pattern of investigative development, with outcome measures broadening to include quality indicators such as employment status, income, and social activities, alongside the traditional indices such as recidivism and degree of symptomatology. Wilson (1988) found that the 'hard criterion', e.g. recidivism, were used to indicate high reliability,
were thought to have 'face validity', reflect cost savings, and had implications for prognosis (i.e. evidence suggesting that each successive rehospitalization diminishes a favourable prognosis), and that they could be compared across studies.

The review of quality evaluation studies indicates a transition in values and practice, with a continuing contradiction in the methodology.

First, the focus on quality of life as a primary indicator of the effectiveness of care is a values-based concept, in that it assumes that enhanced quality of life is the outcome for which the service system should be striving. Values-free research would either test this assumption or focus upon readmission, for example, as a primary indicator.

A second research dilemma is the question of empirically defining quality of life. The values-based approach should be used to measure according to each persons' own definition (Wilson, 1988), although such a degree of individualization is 'not typical' in the quality literature.
The Educational Transition and Community Care

An alternative to clinical, psychiatric, approaches to mental health is evidenced by examining the socio-educational literature. Characterized by reflexive personal stories, and written and pictorial descriptions of individual experience and records of collective action (Freire, 1972, 1985; Shor and Freire, 1987; Horton, 1983; Hall, 1984), adult education is demonstrated in the practice of sociologists at work in mental health care (Wolfensberger, 1975; O'Brien and Lyle, 1987; Mount and Patterson, 1986; Mount, Beeman, and Ducharme, 1988a). In this approach the evidence of the investigated people is instrumental, as what individuals do becomes a critical basis for knowledge (Polanyi, 1958, p. 60; Torbert, 1981, p. 145; Wells, 1985; Rose and Black, 1985). The basis for this approach can be seen in the context of the evolution of methods of learning through collective community action (Habermas, 1971; Freire, 1973; Horton, 1983; Hall, 1984; McKnight, 1987).

Thus, a cross-disciplinary analysis reveals what is, in effect, a theory of social devaluation applied to people who use mental health services. The
professional response in this case is to use educational methods for training health care workers in the empowerment of the less powerful people who leave mental hospital.

Like Mezirow (1981), Knowles (1984), and Jarvis (1987), advocates of community-based mental health services, Wolfensberger (1980), Mansell et al. (1987), and Casey (1987), also assume that students are (i) able and (ii) that new experience will lead to new knowledge and enhanced skills. Neither the experiential teachers nor the mental health care trainers examine the personal process involved in getting to know. However, research in the field of science teaching formulates how personal methods of learning work (Pope and Gilbert, 1983a,b). This involves recognising a core of personal construing, constructivism (Kelly, 1955), inherent in educational practice and student learning.

Although the development of personal knowledge through constructivism is evident the early emergence of the Australian action research literature (Kemmis, 1982; Kemmis and McTaggart, 1982), it is either unacknowledged or neglected. Additionally, Kemmis and McTaggart make liberal use of terms, without
acknowledgement, from the literature of Third World educators, exemplified by Freire (1972, 1973). For example, the notions of empowerment of devalued people and critical moments in learning predate their use in the action research literature. However, the Freirean principle and Kellyan influence is developed in the literature (Pope, Watts, and Gilbert, 1983; Pope and Novak, 1985; Pope and Denicolo, 1986, 1989; Kemmis, 1989; McTaggart, 1989).

An alternative to a strict dichotomy or hierarchy of knowledge is evident where the focus is upon democracy, individuality, and participation. Mount, Beeman, and Ducharme (1988b) demonstrate the educator's role as a community member engaged in bridge-building between hospital and community. This role empowers people as learners in continuing education to act self-sufficiently (Dhar, Tandon, and Pandey, 1987).

The move away from a focus upon personal experiences in school is referred to as reflective learning by Jarvis (1987) and transformation of experience to knowledge by Mezirow (1981). The socio-educationalists, referring to the synthesis of cross disciplinary evidence above, advance further the
notions of experiential learning and reflection to the person as the source of knowledge (Horton, 1983; Hall, 1984; Freire, 1985; Shor and Freire, 1987). The enquiry which formulates and gives further authority to the non-clinical advance being linked together here, is generated by personal construct researchers in the field of science teaching. This literature links an evolved method of science education (Pope and Gilbert, 1983a, 1983b), with andragogy (Knowles, 1984), and participatory educational research involving people on the margins of society (Freire, 1985; Shor and Freire, 1987) with those who use mental health services.

Trainers in the field of mental health care have attempted to implement similar ideas, without a conceptual educational base. Wolfensberger (1980), O'Brien and Lyle (1987), and Mount, Beeman, and Ducharme (1988a,b), have moved to less formal methods of teaching as the process of closing mental hospitals began to impact upon American communities in the 1970s. The shift by these trainers from a focus on deficits (teaching staff about mental illness, for example) to assets (valuing people who are disabled by equating them with 'ordinary' citizens, for example) is similar to the shift to experiential learning that
is extended by the educationalists who use a constructivist approach. In effect, mental health trainers and researchers studying the relation to education of personal constructivism are asking similar questions. For example, what makes a person unique? Their approach to research not only offers a potential transaction between 'teller and listener' (Mair, 1990) but also the genesis of a unifying transaction between the human and natural sciences.

Learning has been transformed from simulated actions to action that requires personal commitment: this is the principal link connecting adult educators to teachers who work with people whose social roles are seen, for example by normalization advocates, to be devalued by investigators operating from a clinical paradigm.

The non-academic and non-psychiatric position in the literature is polemic because the methods of teaching and research have become informal. The key players either confront and reject psychiatric initiatives (Wolfensberger, 1987; McKnight, 1987) or publish their work in networks or newsletters outside the mainstream literature (Hall, 1981; Tandon, 1981; Faundez, 1988). They have become political, with a small p, by moving
beyond the parameters of professional training and public administration. For example, by valuing the personal knowledge of a practitioner-student, the process of empowering the student and disempowering the teacher is underway. By acting as a collaborator with students, the teacher and the method has been associated with political implications because of changes that individuals wish to make within bureaucratic systems. There would seem to be a suggestion from the polemic camp of the literature that formal training does an injustice to people using public services. Wolfensberger (1987) goes so far as to call it "the new genocide" by the paid worker of the unpaid service user.

The knowledge used by self-help support groups is similar to that of both the experiential teachers and the informal researchers. A critical denominator of self-help mutual support groups, such as Alcoholics Anonymous, is experiential knowledge (Borkman, 1976; Gartner, 1976; Borck and Aber, 1981). Experiential knowledge is defined by Borkman (1976) as:

truth based on personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others.

(Borkman, 1976, p. 446)
Differences between native and western science will now be used to conclude this critical perspective, which was first entitled The State of Getting to Know. My awareness of the link that exists between knowledge and its uses has been heightened by my practical and teaching experiences with people who use and work in psychiatric services. This section of the literature review has identified that link as a gap that is bridged by educational researchers using personal construct methods of enquiry. Participatory researchers would not bridge the gap in the same way. They emphasize the link between knowledge and its uses (i.e. technology, social policies, religious beliefs, etc.) and the economic-ideological power:

With knowledge as its instigator, social transformation has begun in Latin America causing intellectuals to become indignant at the reactions of the popular class against the dominant economic and ideological model. They become indignant because the intellectuals themselves have become mere foremen of the State.

(de Souza, 1988, pp. 29-30)

The use of knowledge becomes an ethical consideration in research methodology, although participatory research has not established the personal learning process involved in generating new knowledge.
The way that knowledge is used will value some interests and be seen to devalue other interests. If I am a disabled person or a migrant farmer, I may disagree with the trained and paid carer or the degree-bearing farm owner that knowledge is being used in my interest.

The search for appropriate curricula and educational experience itself, would, therefore, need to be argumentative or deliberative in nature. If, as de Souza (1988) argues, this is contrary to the traditional conception of research that values the logical-form and statistical criteria, it is necessary to establish a link between hypothetical reasoning and proving requirements on the one hand and argumentation by researchers and participants on the other.

Health professionals are particularly subject to complex changes and pressures in modern life, and increased demands have been put upon professional education (Rogers and Lawrence, 1987). A professional works in a certain area of knowledge and skill, is guided by attitudes and values, and is influenced by the environment where the work is set. The interplay between learning and action in the practice setting may be one-sided, or not, depending on the methods of
enquiry. This section of the review balances a consideration of the standards of knowledge with an examination of enquiry methods behind the standards. Teaching and learning per se is the cart behind this horse; these aspects of the educational process are experimental by-products of my research.

A Synthesis of the Literature Review

What can be learned from the experience of the review? What learnings over the past decade illuminate the role of today's educator in the mental health field? What is the importance and use of personal knowledge, given the changes and shifts that have occurred? Can research empirically characterise values by developing a constructivist approach to self-discovery?

My preparation for this research, the identification of a problem that recognises the relative absence of personal knowledge as a core construct, and the acknowledged incoherency of applied methodology in the field, support an argument that mental health care is a personal science. A hypothetical assumption of the relevance and utility of acquiring and using a personal constructivist approach to research has been hewn from striking the mortar crust off the
methodological bricks of the past -- a personal analogy in reference to my everyday view from my rooms in the hospital, as sub-contractors of the Tesco Consortium retrieve and clean each brick as the one-time asylum is cleared of its buildings.

There are two parameter sets that are challenged by an alternative approach to investigation. One is the pair with descriptive and prescriptive methods as its poles; the other is the pair with diagnosis and prognosis as its parameters. The literature review demonstrates that the stage of questioning of what guides conventional science requires the exploration of anomalies or problems that resist solution in mental health care.

There is an inherent conflict of interest between what is good for one person, service-user or direct-care staff, and what is good for a whole group of people. There is also a conflict between what may be of benefit to 'the system' and what may be of benefit to patients or employees.
Logically, families and individuals have a contribution to make in dealing with the issues affecting their own lives. None of the major issues in peoples' lives can be addressed by professionals alone.

The Literature Review seeks to discover constructivist linkages that form an empirical basis for preceding with research, following transition to community mental health care. The investigation seeks an approach that has the capacity, relevance, and utility, to provide guidance for people who live and work in a world where there may be no consensus on reality at the same time as they exist in their own changing world of complex, abstract, concrete experience.

The literature Review has examined the social impact upon individuals who move from mental hospital to a community residence, as measured by the person's ability to function. Another aspect of the review examines an investigative focus the deficient use of language by people with schizophrenia. Alternatives to long-term hospital care and longitudinal studies demonstrate varying research methods being employed with similar outcomes. Community care is portrayed
in different ways, depending upon the purpose of studies and the inherent self-interest of sponsors. In contrast, the common experience of people who use mental health services is how they are treated, not how they are as schizophrenics, for instance. A professional culture of validity develops for what knowledge is to a psychiatrist, for example, and this is not the most meaningful or useful knowledge from the point of a user of mental health services (Chamberlin, 1979).

How can the knowledge of mental health service users and support workers be validated to enable them to cope with constant change, increased complexity, and continuing uncertainty of personal reality? Are there unlimited alternative constructs of vision and perceptual maps, each residing as a unique response and regenerating as new knowledge in a moment of personal interaction?

Considering the literature so far, there appear to be four constructions to the review:

1. A range of outcomes from stasis to dynamism in an enquiry, regarding what it reports about the knowledge of participants, is affected by the approach
used. Generally, research into the transition from hospital to community care shifts its focus without changing its method. Social and political alternatives to hospital care, outside the United Kingdom, have used conventional methods before and after discharge.

2. Methods of enquiry are applied to assumptions of need that focus on deficiency. There is a tendency to validate the thesis of an assumption in proportion to the development of a profession's practice. Investigations of a social need for people with mental health problems yield data and analysis that contain a mechanism for making predictions about prevailing assumptions. New knowledge is largely research artifact.

3. There is a shift in staff development to a more professional, formal, and academic status. This occurs alongside significant, public reviews of community care. Both of these current developments skip-over educational thinking about services for long-term users and workers in mental health care.

4. Informal methods of teaching are being developed in the field of mental health care. They focus on citizen-based action and the competency of a
community to care. They are linked in the current research to the prior experience of Third World educators, who have made adult education accessible to poor and disabled people by recognising their gifts as human beings. While this movement is a minority in education and research, it occurs alongside a shift toward personal experience in further and higher education. Teaching methods and theory are directed toward personal knowledge. Native science and the self-help movement serve as an influential backdrop in the process of research into learning and knowing.

These tiers of effort, which operate in tandem but are interconnected in a critical analysis of the literature, encourage an alternative approach to investigation that may or may not substantiate the relevance and utility of a constructivist approach to self-discovery, from an educationalist's point of view. Identifying a constructivist paradigm through linkages in prior knowledge creates a way of seeing multi-realities that integrate conventional, monological concepts born of individual professional disciplines. The literature review demonstrates predetermining constraints of single professional
approaches to understanding and explaining reality, in the context of new research in the transition from hospital to community care.

The next thesis chapter examines (i) 'baselines' of care inside and outside of hospital and (ii) a personal dimension to mental health care as a human science. It provides a reflexive corollary of the themes and issues in the literature review while describing a stranger's struggle to find active, practical ways of being with people, as experience is reconstrued, new knowledge regenerating from the questing of a care-giver and a service user.
CHAPTER TWO

A CASE OF DIFFERENT LIFE EXPERIENCE
IN MENTAL HOSPITAL

This chapter identifies baselines in the present study. Comparisons are established between hospital and community life, and between staff and patients. The hospital-community, staff-patient analogies identify two of three bases on which the research in this field is conducted. A third baseline, or dimension, is the connection between the bases. A reflexive, personal account by a stranger, the current researcher, reveals his initiation to practice and inquiry. Prior research (identified in the Literature Review) is, in the main, two-dimensional. This point of departure in the present research is its study of a three-dimensional context, by focussing upon the dynamic personal baseline.

The self-characterised account that follows will depict a personal approach to patient care, more by intuition than theoretical construct. The question
is, in light of the literature, is there potential for a more useful approach to the patient's potential than an impersonal approach to care. As Schon (1987) puts it: the practice of believing the other person's point of view rather than our own "makes communication itself problematic in a way that corresponds to our actual experience" (Schon, 1987, p. 230). The science of nursing, after all, connects research and practice as a mechanism for establishing the relevance and use of new knowledge (Treece and Treece, 1977; Wilson-Barnet, 1983; Peplau, 1988; Pringle, 1989; Couchman and Dawson, 1990).

'Home' in the Mental Hospital

The archives at the hospital record that in 1903, when it opened with 27 wards and 750 patients, it was unusual to have a mental hospital in London or in any other city. Up until that time, most of the asylums serving the city had been built in the depths of the surrounding counties, "underlining the embarrassment of the Victorians at all manifestations of Mental Illness" (Watson, 1984). This hospital was unusual in that it admitted 'non-certified' patients over the age of 70. The location made it accessible for relatives or friends to visit the people who came to the
hospital as an alternative to home. By 1926, the hospital had 67 wards and 2,000 patients, compared in 1990 with 17 wards in use for 380 patients.

Expansion of the asylums was unexpected; the spirit of optimism and reform that produced small-non custodial asylums gave way to the equally unexpected scale of the problem of mental disorder (Social Services Committee, 1985). The construction of enlarged, often remote, institutions has a direct link upon present-day services:

The present pattern of services for mentally ill and mentally handicapped adults is, more so perhaps than many other form of medical or social service, a product of history...

(Social Services Committee, 1985, p. xi)

The stranger first reported for work at the hospital in September 1977. He stood in front of the locked door, gazing at the floor in contemplation of the names that people were called who were mental patients: insane, idiot, moron, demented, imbecile; rabidness, out of one's mind, unhinged, loony, maniac, berserk, possessed. There were more names than he had imagined in his current thesaurus (Brown, 1972). Of
the 500-plus names he'd found the night before, under
the headings Unintelligence and Insanity, many were
slang words, e.g. bats in the belfry, a screw loose,
lame brains, pink elephants, booby hatch, goof, coot,
loon, dipso, crank, alienist, have a button missing,
froth at the mouth, have bubbles in the think tank,
lose one's taffy, addle the wits, loco, daffy, just
plain nuts, nobody home in the upper story, Tom o'
Bedlam. Of the 34 paragraphs that described insanity,
only four referred to psychiatric conditions, e.g.
schizophrenia, Alzheimer's disease, Korsakoff's
psychosis. What could have caused a problem for
people to be called such names? What was the relation
between the problem and what people thought ought to
happen to these sufferers?

The spacious green grounds were tidy and flowering, in
contrast to the public face of the hospital: high
brick walls, cast iron railings, caged second-story
cat-walks connecting the blocks of dormitories, with
the imposing Victorian architecture. When let into
the ward, the stranger found two men on the other
side. The ward nurse had reached between them to let
in the visitor. The two men wore pyjamas. They gazed
at the floor, also in contemplation, it would seem.
His instant impression from the threshold was of a
different reality, a different vision, with different values and different beliefs.

H2 Ward was a 'typical' hospital environment to live in, given significant accounts by others (Wing and Brown, 1970; Altschul, 1972; 1981; Towell, 1975, 1980; Martin, 1984; Roth and Bluglass, 1985). By typical it is meant that when people are congregated together there are institutionalising effects that compound their mental health problems. These effects are well-known in psychiatry as institutional neurosis (Barton, 1976), or in contemporary terms, an institutional frame of mind from which people get better (Healy, 1990). The loss of personal identity was coupled with a lack of occupation and a stereotyped role within the mental hospital. Patients became alienated, both personally and socially (Yoder, 1977). Rather than focus on the 'mental bed sores' of hospital life (Barton, 1976), contemporary investigators have identified hospital life by comparing it with what is missed-out from ordinary living in the community (Wolfensberger, 1975, 1983; O'Brien, 1987; Towell, 1988; Knapp et al., 1990). The missed-out experiences included personal
closeness to 'ordinary' people in everyday situations: having a place in the lives of others and control over personal situations.

For these latter, non-psychiatric investigators, the measure for what is ordinary is the comparison between the personal experience of the investigator and that of the patients. In this way each person who is a carer is a personal researcher who uses what s/he values about his/her own life to evaluate the quality of life of the person being cared for. For example, the carer might draw in the mind's eye an imaginary circle with a box in the middle in which the word 'Home' was printed. Lines might then be drawn from 'Home' to indicate where the carer goes during the day, with whom, for how long, and why. In this way, a 'community map' is constructed for the carer. It indicates what connections the person has with other people and places. It may also depict what the carer values in life, i.e. friends, the church, the market, and what roles are valued, i.e. wife, husband, worker. The concept of normalization (Wolfensberger, 1975, 1983; O'Brien, 1987) is derived from this logic.

This latter sociological research has not been related to self-characterization (Kelly, 1955; Bannister and
Fransella, 1986) as a technique of inquiry, any more than the psychiatric research methodology that preceded it was consistent with normalization. However, it was important for the stranger to construct a cross-disciplinary framework that is person-centred and practitioner-oriented. An educationalist would require an alternative approach, that is to a psychiatrist, for example. Secondly, to investigate only one dimension of the field would conceal the growth of knowledge inherent in a multi-dimensional approach to research.

Reflecting upon personal experience, H2 Ward was a cogent example of the difference between life inside hospital and life outside. The H2 kitchen was for the use of the domestic helper and staff. It was the one unlocked place that the stranger noticed patients did not go, although at times it was locked. Across from the kitchen was a bathroom with two tubs and five wash basins. During the 1970s, it was common for bathrooms to be drained via an open gully, where the water flowed along a gully round the outer edge of the room, from the basins and tubs to a drain and out of the room.
Having walked in silence past these two rooms, the first person to use words was the staff nurse, who had unlocked the door for the new employee. The charge nurse was introduced. After a brief exchange of information with the night staff, he was taken by the day staff (the staff nurse and the charge nurse) to the dormitory to count the patients. Breakfast was at a particular time, so the patients had to be ready.

The patients shared living quarters. They worked, slept, and ate in H2 Ward. The jobs they had within the ward included keeping their bed area tidy, cleaning the tables upon which food was eaten, and sitting in the communal dining/sitting room. Although no money was paid for these jobs, they were required by staff to do this as part of their personal responsibilities.

He found that the bathroom was a crowded and difficult place to work. People seemed to be on-edge, as if from a bad dream. As a newcomer, this would be part of his morning routine. Yet, it required intimate knowledge of each of the people. Bathroom work was not a preferred job, from the point of view of the charge nurse, or his staff nurse. Therefore, the nursing assistants and students were assigned to
supervise bathroom activities, such as shaving, bathing, washing underwear in the basins, and getting dressed. Congestion in the ward was most severe in the bathroom at the start of the day, with the time pressure of breakfast making a queue at the basins.

The particular kind of mock-silence in the early morning bathroom perhaps best identified the differences in consciousness between staff and patients. While it was important to maintain order and tend to peoples needs, the liveliness of the patients internal communication was unobserved. In his early days of employment as a care assistant, and thereafter, the stranger found patients were troubled on waking by the fluctuant and unstable mental representations they had experienced during the night. He tried to imagine what he would be like if the odd bad dream he had occurred every night. His dreams involved clear visualisations of people in action. The patients who described to him their difficulties at night said that they had dreams that were frightening.

The staff began to tell him things as a part of his 'learning the ropes'. This teaching shared one common assumption about all of the patients: that they could
not experience growth and development. Some staff said this was God's will, others said it was due to sin, fate, due to different types of problems, physical causes, that it was hereditary, contagious, or without rationale. The person was seen as, respectively, evil, a holy innocent, sinful by choice, hopeless victim, an agent amenable to change, sick, a danger or menace, or a burden. Logic would have it that if there were so many origins that resulted in the person being seen in so many different ways, then the response, or goals of treatment in care would also be multiple. Given the number of definitions of the problem, examples of goals would be to protect society, have mercy and pity, punish the person and protect society, use specialist training, protect the individual, make a diagnosis and cure the person, protect society, or institutionalise them. Yet what the stranger experienced was that all of the patients were dealt with, socially, in the same manner, despite there being several different explanations of the origin of the problem.

When he became a student of nursing, the definition of the problem became more focussed. However, while the focus for learning tended to be upon types of psychiatric disorder, physical causes, and hereditary
conditions, the assumptions of staff who he knew were reflected in institutionalised practice. For example, he continued to find staff wearing rubber gloves when touching patients and using freshly-cleaned towels when sitting on patient furniture. One might expect this during an aseptic technique, for instance the changing of a deep bedsore, but not for bedmaking or helping patients to shave. This behaviour was in evidence in 1990, albeit much more discretely. In his experience, this sight was a daily occurrence in the late 1970s and early 1980s. The point is the extent to which life in the hospital can be determined by how staff think about patients and what they do — a missing element, the stranger thinks, in the effort of prior studies to produce objective findings.

Wolfensberger (1975, 1987) asserts that the hospital culture and staff behaviour derides and devalues the experience of patienthood, representing an unconscious expression of the values and beliefs of society as a whole. These values and beliefs are repressed, but Wolfensberger would argue that they are nonetheless damaging, 'wounding' to use his expression, to patients in institutions.
When the H2 Ward food trolley arrived for breakfast, the patients lined up and the plated meals were handed-out. This was not a job for the uninitiated assistant. The dispensing of food, sweets, cigarettes, money, and medicine, was associated with the behaviour of the patients. It was an important task and appeared to be associated with the status of the psychiatric nurse. The patients would go to their usual chairs to eat, while he fetched the drugs trolley so the nurse could prepare for the medicine round.

Before training as a nurse, the stranger was sent to many of the hospital wards, because workers were used to 'cover' for sick staff. This procedure was called 'booking-out'. Because the nursing officer in charge of the hospital did not know how well the hospital was covered by staff until after s/he started duty, the booking-out inevitably came amid a sensitive early morning social encounter. For example, the transition from sleeping as an activity, to being conscious, and from being alone to being with people in tight spaces, was fraught with conflicting viewpoints, anticipations, and frustrations--referred to earlier as mock silence. The stranger found himself, especially on male wards, entwined in acrimonous and
physical violence. It seemed to him a fool's folly, because the incidents bore no apparent relation to the depth of distress, e.g. 'over' a missing towel, an unguarded whisper, a misplaced sock. Inevitably, these situations were interrupted as the hospital made adjustments in staffing. This procedure seemed to be so much a part of the life for staff and patients that any effects upon the quality of care went unnoticed. Typically, the stranger was called away from helping a palsied man cope with shaving, to attend another ward to find a lady laid bare in the process of being 'topped-and-tailed', when a lone staff member had been distracted from her wash. It was not uncommon to be sent from acute care, to long-term care, to elderly care, to secure care, to care of the drug dependent patient.

The hallmarks of H2 Ward, and the other hospital wards, were a scruffy decor and well-worn furnishings, as well as an overriding feeling of lack of space. Very few, if any, words were spoken in the bathroom, for example, or over breakfast, lunch, tea, and supper. The stranger found that there was little support for interpersonal relationships or socializing. The relative absence of constructive activity to establish and maintain interpersonal relationships has been demonstrated to be
depersonalizing (Menzies, 1960; Stockwell, 1972; Towell, 1975; Altschul 1972, 1981). Yet, this technique, which Laing (1965) referred to as depersonalization—the act of turning the patient into a thing, actually petrified patients. Patients had become as passive as the former inmate role described by Goffman (1961).

The lack of sociality seemed to fit the context of the physical presence of the hospital. H2 was on the first floor of a two storey dormitory-type building. These buildings were lined up along three sides of the site, giving 67 wards of accommodation, plus room for a number of other activities, such as industrial therapy, and rooms for the hairdresser and dentist. Most patients could leave their ward if they asked one of the nurses for permission to do so. But it was not untypical to lock wards 'for non-certified' patients, in 1977. The practice continued, at the discretion of nurses, through to 1990.

There were four main rooms for patient use in H2, each with a clear function. These were sitting, eating,
sleeping, and hygiene. The sitting room had empty carpeted space in the middle of the rooms (elderly care wards did not have carpets due to the incidence of incontinence, although they were introduced in the mid-1980s). A television occupied a shelf at one end of the sitting room. Music was available through a speaker which was turned on and off manually at the speaker, which was 10 feet off the ground and situated next to the ward clock. The staff and domestic helpers used a dining room chair to turn the music on or off and to adjust the volume.

The dining rooms were equipped with large canteen type tables, seating up to 10 people, and plastic chairs. The sleeping rooms were shared dormitories. Cubicles were introduced in the mid-1980s by hanging curtains on a frame that surrounded the patients bed and side-table. Each patient had a single bed, with a three-foot high, two-foot square dresser. Later, individual lockers, or wardrobes, were introduced, although the ward linen room with a stock of hospital clothes continued through the 1980s. Also, during the 1980s, side-rooms, that had in the past been used for
seclusion, increasingly became the personal room of more able patients. By 1990, non-florescent lighting, carpets, and partitions had been introduced.

Patients were urged to attend the departments of Occupational Therapy or Industrial Therapy. The stranger found that nurses and other workers were worried and frustrated at the majority of patients being bound to stay in H2, pacing or sitting and in either case being stoic or animated in a way that was not understood. Televisions donated by the League of Friends were in constant use. To the naive initiate, the ward TV was a perfect gift. After all, where there was no apparent reality for the patient, what better than a TV to help the patients keep in touch with reality and be entertained?

However, the pleasure of real events and entertainment seemed to be derived from other sources. The stranger's first impression in 1977 was of being confounded by his dismay at seeing most patients chain-smoking, the extraordinary speed at which they
ate their meals and the brief, often monosyllabic, conversations between them, and between them and their nurses. The most typical interactions concerned smoking, sweets, and questions from the patients about where they could go and the doctor's whereabouts. However, in a place with so few pleasures, how else or what else would produce a satisfaction, given the predominance of so many different views of reality that were not acknowledged, accounted for, or noticed for what made them unique. And if the pleasures, such as they were, ceased to be satisfying, then perhaps doing them with more enthusiasm might become more pleasing.

Patients on H2 Ward and elsewhere were served meals and drinks. The maintenance of this service, keeping order in the ward, and tending to the patient's hygiene were principal preoccupations between patients and the staff. Nurses made all the beds and this was an important activity in 1977, although by the mid-1980s the hospital was starting to change. Most of the time spent by trained nurses was in office work, e.g. keeping records, answering the telephone,
reporting to others, handing-out slips of paper enabling patients to draw money from the patient's bank. The untrained nurses and students spent most of the time keeping track of people, letting people in and out of the ward, giving instructions to patients about washing, dressing and eating.

The casenotes, or medical records, were kept in each ward office. They contained a catalogue of disbelief about the knowledge claims of the people the stranger was meeting. For example, Mr. Mann was reported by a number of staff of all grades, from doctors to nurses to social workers, to have a 'poverty of content'.

This refers to his view of the world, compared to the view held by those people who treat and care for him. Mr. Mann's view of himself as King and Knight of Jamaica is a rich tapestry of belief and enthusiasm for his 'culture'. The case records contain a vocabulary that counterpoints the patients' views with alternative views. The preferred view, to the untrained but logical mind, constrained any opportunity for learning, growth, and development.
Mr. Mann

This man's pride and meticulous nature was reflected in the way he carried himself, nevermind the careful and elaborate defence of what he thought, his ideas and his aspirations. For a person to be ridiculed for an unconventional view, or given a label than is not valued by the labeller, has been described as a vocabulary of denigration (Laing, 1965). Mr. Mann's choice of words diminished to a form similar to newspaper headlines, in response to the vitriol of his carers. His gait was bold and upright, in keeping with the stern defences he had to make on a daily basis, of both his views and his values. When Mr. Mann and the stranger first met, he had not eaten food by mouth for nine years (Lemmer, 1978). The stranger's introduction by staff was to Mr. Mann's paranoid schizophrenia and the tragic events that are contained in medical notes.

On reflection, this relationship taught the stranger that, in the case of Mr. Mann, if treated as a solution rather than an approach to care, nursing would have to entail a vision for a better future. More important, a belief in the capacity and potential of Mr. Mann to have a valid way of knowing, to learn,
and to develop, proved instrumental in this case. That process would include the active participation and valued collaboration of the patient. Yet the institution's evidence of this man's experience was a catalogue of what it views as mistakes, violent incidents, and interpretations about him that indelibly mark him as being too different to be held in normal regard. While his demeanour seemed strong as his posture was straight and his gait 'sure', his existence in contrast was undignified, in the way he was clothed, the distance he travelled in the ward, and the quality of his relationships.

Mr. Mann 'possessed an unshakeable belief', to use a phrase from the case records about him. The uninitiated might be forgiven for thinking that this might suggest he was possessed and that his beliefs should be shaken out of him. He said he was a King of England, in hospital "to pass through government, to acquire arts and sciences"; to be liberated when the "move" was made, resulting in a war between the avengers, communists, and others, allowing him to return to his "generation" and assume his position as King and Knight of Jamaica. He had been fed through a naso-gastric tube since January, 1968, four years after he was put into hospital.
The medical records note that on admission to hospital, he was immaculately dressed. Following a domestic argument, the police were called to his home. He was detained under the then-Section 29 of the Mental Health Act. As a process of compulsory admission, his fine hat, his suit, shoes and all other personal effects were taken away and he was put in a locked ward for compulsory treatment.

Mr. Mann seemed suspicious of things around him. Staff made it clear to the stranger, as part of his introduction to the ward, that Mr. Mann disliked almost everything. He was said to be apathetic, unemotional, and depressed—much like his environment, it could have been said. Apart from a morning wash in the bathroom, and a standing look at television news, as he passed between the bathroom and dormitory, his movement was confined to a daily stroll from his bedside to the medicine room, where he was tube-fed.

The plan of the then-student was to conduct an informal experiment, the hypothesis of which was this: if Mr. Mann could invent such a self-construct, i.e. seeing himself as George and so on, then similarly he could revise the construct by generating new ways of
knowing, with the support of a critical friend. He learned 40 new tasks and after 48 days he was independently feeding himself through the tube (Lemmer, 1978). One at a time, for all of the things that the nurses did for and to him, he accomplished these procedures in his own unique way. For example, when he broke the eggs into the dry-food mixture, he did it with verve, as if the eggs were for someone special. Such was his energy and enthusiasm that the thrice-daily procedure became very time-consuming. He stopped, after two-and-a-half months, and began to eat food that was served in the dining room,

On reflection, a deliberate attempt to validate what he knew resulted in him being available and accessible to share and trust the views of the student. Mr. Mann was more than the paranoid schizophrenic who thought he was King of Jamaica. It was even ironic that staff did not believe him, when the reason for his admission was the existence of his beliefs. This was ironic, with hindsight, when the stranger as a nursing student elicited a unique response from Mr. Mann by avoiding a confrontation about the rightness of what he thought he knew.
The student was enabled by Mr. Mann to teach him the entire staff procedure, i.e. from fetching a trolley and proceeding to the kitchen to prepare his milk and egg base for the Complan feed, to lubricating and inserting his tube, to washing up after the feed and returning the equipment.

This example of care demonstrated to the student the experimental nature of psychiatric nursing. If human conduct was an experiment, open to revision, even in madness, then integrating the mechanism for knowing, i.e. the inventiveness of being and acting, might create the opportunity for revision. A relationship of trust and the time to construct a relationship were important. However, on reflection, the most significant feature of this case is the practical acknowledgement of personal meaning that is unique to the other person, Mr. Mann. Whilst other schizophrenic patients had delusions, they were not the same as his but all delusions were put into the category, for the purpose of diagnosis. Although the stranger was allowed to write new rules for being with Mr. Mann, this was a contradiction of life in the hospital. Nursing care was seen as an institutional approach to the patient rather than a solution to his problems.
The stranger, then student, then researcher, looking back upon his self-in-action, sees a question arising for investigation. If personal care has as its focus a testing for personal validity and viability, would patients find more opportunity for self-care? How would it be recognized that patients' ways of knowing could lead to their self-invention of ideas that resulted in good practice for carers and patients? Having stopped the tube-feed, would Mr. Mann then decide to return to it, after the student left the ward for another placement? In this case, there seemed to be a proliferation of other ideas. Having increased his geographical use of the ward, he began to go outside, into the grounds. By 1990, he had gone as far as the zebra-crossing, just outside the hospital front-gate. (Then, that part of the site was sold, to finance the opening of supported houses for long-time hospital patients to live in, and Mr. Mann returned to the ward, rather than use the new front-gate on the opposite side of the site.)

Of course, Mr. Mann may have thought he had no choice except to eat food in the conventional way. There was never a certainty in the student's mind that the permission, participation, detailed individual care
plan, and fact of the student's leaving, were exactly shared as a point of view. The nurses, who had spent several hundred hours a year feeding him, avoided any involvement in the procedure after the student went to another placement. It had become clear that shared meanings were unreal. In this case, mental hospital life makes that explicit. In addition to the apparent impossibility of relatively exact, shared meanings, there was a dimension to mental hospital work that made this an unavoidable logical conclusion: people who use this kind of a service have invented, or constructed, views that, while individually unique, are outside the reality of people who provide the service. But then the same might be said for staff.

Following this experiment, the student and Mr. Mann seemed to have different views and different behaviours, than before they worked together. Embedded in this experience is the question of what it means to know. Is it good practice in mental health care to value the knowledge of people whose views are so different? Did the process of new ways of acting lead to new ways of knowing, with or without regard to the so-called deluded ways of knowing? Is it necessary to
find-out the method of constructing what is known? Or is the cause of the method, even in madness, an injustice to the construer? If it is true that knowledge in terms of how it is individually interpreted is universally different, then would it be the case that mental patients would have just as much opportunity for inventing new applications of it for daily living as would anyone else?

It would seem to follow that a change in the external reality of a person, i.e. what he does that is confirmed by another person, is connected to a change in his internal world, i.e. what he thinks and feels that is private and not public. His view of himself could be a construction under constant revision, influenced by self-inventions based on what he knows or upon revision following experiments, or both. But the human being must then be always vulnerable to act upon findings that are inadequately tested.

If nursing was a solution to problems more than an approach, would the staff and patients be in a better position for preparing for community living? If the critical self-understanding of patients and staff was
enhanced by a solution-oriented approach to care, would it be unnecessary to focus on anything other than a more desirable future for both?

The student experienced his early days of practical and theoretical life in mental hospital as a struggle to keep knowledge bases separate -- the way of knowing of the staff and the way of the patients, as if it was that simple, in two dimensions. If the self is an invention based on the person's comparison with another or others (arising from interpersonal or personal experience), can work outside of the person be considered as a help in the healthy revision of an incoherence of knowing inside of the person?

Methodological Implications of the Third Dimension

The psychiatric nursing background to the present study has the effect of producing a three-dimensional double helix, bound by past practice and prior research. The practice helix spirals from the experience of patients in mental hospital, where the present research participants lived, with the stranger's prior knowledge as a psychiatric nurse, before the present research began. The practical spiral tracks the demands upon the nurse and upon the
patient to find-out and know the meaning of their self in relation to the other. This chapter's biographical reflection is a finding of an inextricable third dimension in the relationship between research and practice. It is also a revelation of the practical origins of the present research. However, using the helix as a symbol indicates an assumption that a method of knowing (a) contributes to well being and (b) is a 'given'? How could it be, when both social labelling and psychiatric diagnosis indicate to the contrary, that there is, to elaborate on an old adage, 'method in their madness'. Is the very self-invention that indicates mental illness also a mechanism for recovery?

Research is the second helix, spiralling from questions that arise about the nature of health needs, through the testing-out of an individual nurses responses, to validate or falsify a hypothesis, then to revise the practical intervention, consistent with new findings. As a basic life process for the stranger, the double helix represents experience of a symbiotic relationship between inquiry and practice. It takes the theoretical argument of nursing research (Treece and Treece, 1977; Wilson-Barnett, 1983;
Peplau, 1988; Couchman and Dawson, 1990) to its logical conclusion in patient care. However, how can there be individual illness if, as suggested, the construct of self is bipolar? Is madness a construction? If the construct of self is dependent upon a comparison between people and/or experiences, then (a) institutional neurosis could be more easily understood and corrected and (b) the nurse's therapeutic work (Barker, 1990) could be applied to empower the act of self-construction as a healthy endeavour.

There is evidence, albeit scant, in nurse education (Edmondson, 1990) and in residential work (Emerson and McGill, 1989) that a move away from the Cartesian, positivist approach to care and research is the logical and natural conclusion of past practice and research. On the grounds of both effectiveness and ethics a constructivist approach in the present study is consistent with the questions being raised. The thinking behind such a move to constructivist methodology is based upon sources of conflict between the ideology of empiricism and the implementation of care (Emerson and McGill, 1989). This conflict was first identified in the Literature Review of prior research and here obtains a significance in
interdisciplinary practice. Edmondson (1990), while not contrasting the differences between methodological approaches to the investigation of mental illness and nursing practice, emphasises the importance of a unitary approach based upon valuing the past experience of patients and staff.

The method of investigation implicit in this chapter would reflect the following characteristics of the double helix:

a) direct involvement with research participants who are known, with a shared prior experience between researcher and participants;

b) a commitment to self-scrutiny by the researcher;

c) the willingness to change personally and/or see theory and/or experience in a new light.

The conflicts and gaps between ideology, implementation, and empiricism are further explored in the methods and ethics chapters of this thesis. The baselines of research identified in this chapter point to the need for a methodology that is consistent with practice. In the case of Mr. Mann, the method would reflect the mutual misunderstandings and self-inventions of patient and nurse as necessary to
knowledge-making, testing, and revision. The divergence of knowledge in the field of mental health requires an integrating framework for the present research. Methodology must represent practice inclusively, as a multiprofessional model for working with people who have psychological disabilities.

Hooper (1990) and her colleagues found that they had to explore the ways in which nursing knowledge is constructed. Their inquiry, in developing a Project 2000 curriculum for nursing, found that the nursing component is multi-dimensional. Their purpose had been to find a way to manage the transition from an institutionalised curriculum to a relevant and dynamic one. Their position was not unlike that of the present research, where the investigation finds itself in a context of changing baselines and a transition of paradigms. The outcome, in applied research, must be a methodology that is fluid and dynamic. Otherwise, the research could not account for various changes.

Methodology, given the bench marks in this chapter, should contain the double-helix of practice and research. The double-helix as a symbol has a deeper meaning than the baseline analogies between life in the hospital and life in the community and between the
knowing of the carer and the knowing of his patient. This deeper meaning is a third backcloth of the present research. It is a comparison between the conscious efforts of hospital or community care and the unconscious effects of that care. Unconsciousness in mental health services is argued to be a role (Wolfensberger, 1972, 1975, 1987) that demonstrates a record of society's historical devaluing of mental patients. For example, in the discussion of social labelling of patients above, observations of deviancy result more from the ways in which society responds to people in a mental hospital than from the real impairment or difference that originally led to the individual being hospitalised. The difference between medical diagnosis and labelling, and the imbalance of that difference, make this point clear.

Two assumptions underlie the observation in this chapter that self-invention may be a constructivist mechanism of personal knowing and rediscovery:

a) a developmental assumption which would state that human beings have the capacity to grow and develop in spite of their disability, or for that matter in spite of how different they are in any other way. People who use mental health services, and to a certain extent people who work in them, have a number
of unusual things happen to them. On the users side, for example, people can be seen to have been rejected, to have experienced being put apart, or excluded, losing relationships with valued people, and being congregated in a particular place. When this happened, patients and their staff had little control or autonomy. Learning experiences were confused with psychiatric service experiences. Patients tended to miss-out essential life experience -- ordinary experiences that are essential to mental health, and

b) an assumption that the quality of services in mental health care depend on the concepts that staff have as a result of their experiences. These concepts often arise from awareness that is based on and fed by values -- of who the people are, what the people are like, and what the people deserve. The values themselves seem to be based upon assumptions about what causes the problem and what will solve it. If so it seems logical to begin to learn by exploring what these values and assumptions are, through the personal theories upon which they are based.

In summary, the then-stranger/now-researcher, without prior mental health care experience in the late 1970s, was unable to 'take' the patient perspective. Faced with Mr. Mann, he took the position of recognizing
that the rationality of one person may not be the same as the rationality of another. This shift in the way of explaining the unexplainable meant accepting that when these two observers talk to each other the world may not be rational and may not make sense. A shift then occurred in the basis for change, as far as the then-student and Mr. Mann were concerned. They worked in a paradigm that was between their own unique constructions and it was also an alternative to the mental hospital staff view of the patient's psychotic illness. Hence, the finding of an important third dimension.

On reflection, one of the stranger's views is of well-intended staff who have internalised beliefs that fulfilled social and medical values and beliefs about the patients. A second aspect of his present view is of a dispossessed, disempowering experience on the part of patients, such that it may have interfered with opportunities for a desirable future, on a day-to-day basis. In the absence of any validating consensus of such observations, a problem-centred solution to the question of a research design is to 'put' contrasting views in a multi-dimensional context, where alternative explanations can then operate. A three-dimensional synthesis of
constructions about reality opens the field of discovery to imbue the 'informal' alternative explanations with equal standing alongside the 'formal' evidence of hospital and professional data.

This is of particular importance now that the community, with its informal and natural networks that connect people to its services, is a significant dimension in the research context.

This chapter accounts for the formative initiation to a method of inquiring care in the mental health field. It provides a reflective analysis of the other two dimensions being considered in the present research. This description of life in the hospital was intended to identify the baselines for the present research and the context for the development of methodology.

An a priori principle arising from this chapter is that every question is only ever formulated on the basis of an answer. This severely limits the scope of the question! If it was acknowledged that each person possessed a valid but different construct of reality, then the answers, or responses, differ for each person. If this principle were applied in the mental hospital, it would seem from the data of this chapter
that personal care would no longer be an obstacle to 'communication' because there would no longer be a need for replication of personal data. If personal care were not the obstacle to communication then a process of self-discovery about the 'illness' and understanding about the person may be mutually self-validating instead of antithetical.

Once again, the concrete link between research and practice dictates that the present study is about the method of practice and research in practice. A third dimension of prospective research that is being formulated is that of testing ground, for the hypothesis that finds in practice that each person is a hypothesizer, an experimentalist, a theorist in his own right, whether patient or staff member.

In the case of Mr. Mann, it is as though his questing makes him a being in search of becoming in the way he himself wishes. If he can only be through personal re-viewing, then the possibility for succeeding must lie in the ability of his carers to offer alternative constructions rather than contesting or falsifying his beliefs. A desirable future would then depend upon a
potential for self-constructed outcomes of personal enquiry that are neither his or the other person's but that arise from both.

By this analysis, it would be an error to presume that everything is built-up in and between human beings and founded in language. In this chapter, speakers are seen to be experimenting with evident redundancy and poverty of language. The denial of possibility for revision of behaviour through personal reconstruing -- in a person with delusions, for example -- may lead to false deductions about the potential for self-discovery by the people who are patients, and about the relevance to care of personal knowing by the people who are staff.
A personal dimension to science has emerged in the preceding chapters that requires a over-arching frame of reference. The dimension 'contains' personal data that is unreplicable. As a moral aspect of science, the personal dimension is addressed in chapter four: ethics. The present chapter examines issues of knowing and knowledge that underlie the question about a constructivist approach to self-discovery.

From the literature review through to the review of personal professional practice in mental health care, a continuous analytical thread bridges a link between deductive explanation to inductive reasoning. The present chapter moves beyond this position to a paradigmatic investigation within which a personal science for working with people is constructed.
The foregoing chapter presents an example of personal science, where the person is the mechanism for enquiry — in Hunt's (1989) terms, the person is the research method. In my case, the investigative science of a reflective practitioner recognizes and acknowledges that individual patients are also hypothesis-testing. That the practice of personal care forms a double-helix with investigative method is an element in the emerging argument for unity and progression rather than dichotomy and segregation of research method. Seen in this light, there is a 'fit' with the researcher as a carer whose practice it is to be with a patient whose own becoming is constrained or liberated by the same principal process of personal experimentation as that of the investigator (Rose and Black, 1985; Dunnett, 1988; Kenny, 1988; Mair, 1990).

The absence of homogeneity, revealed in the Literature Review, is echoed in a frank exposition by a psychiatrist in the search for appropriate research method:

No two people present with the same difficulty... despite the individuality of presenting patients, we are encouraged to reduce their problem to something identifiable in one or other classificatory system... a catch all descriptive diagnosis which then hangs around their neck like an ill fitting collar that cannot be removed.

(Dunnett, 1988, p. 96)
The present researcher has found, consistent with Nachmias and Nachmias (1976), that scientific research as a process involves particular stages as 'interrelated themes'. The genesis of a research problem has arisen as a natural consequence of both objective knowledge and experience, e.g. reported in scientific studies, and the personal knowledge of the present research participants, by virtue of their experience in hypothesizing and testing out their own knowledge in the process of living.

A Question of Values

Life in mental hospital is different because the beliefs and customs are different from 'ordinary' experience. Institutional values from the foregoing chapters can be compared with the definition of native science by an American Indian researcher:

Through spiritual processes, it synthesizes information from the mental, physical, social and cultural/historical realms. Like a tree, the roots of a Native Science go deep into the history, body and blood of the land. The tree collects, stores and exchanges energy. It breathes with the winds, which tumble and churn through concentric rings—the generations. Why and how the tree does this is a mystery, but the Indian observes the tree emulate (sic), complement and understand his or her relationship to this beautiful life-enhancing process.

(Colorado, 1988)
The values of native science that relate to culture demonstrate the extent to which years of living in a particular way provide a method for knowing that is unique to that science. The power of native science, its meaning, lies in the reasons behind the existence of things, as expressed by Chief Donawaak, a Tlinget (northwest American tribe) elder, who refers to what Raven, the creator, did:

This is where stories begin, there is not story before this...when Raven spirit and Black Raven are working on this land, they put coves in it where you can come in when it's blowing--a place where you can come ashore.

(Colorado, 1988)

Between native and western science the difference is where knowledge comes from and of course that determines to a certain extent the use to which knowledge is put. Colorado's study, for example, refers to the application of knowledge with respect to the bear. Bear, to the American Indian, represents knowledge, healing and comfort. Western science understands bear in terms of rigour, reliability and validity (Colorado, 1988). Research protocols in native science are conversational and informal. They focus on extended family or clan systems to collect data, which, in keeping with oral tradition, focus upon self-expression. The collaborative, endogenous,
heuristic and experiential methods of enquiry implicit in native science are reflected as learning process in the educational literature reviewed in Chapter One.

The comparison between value-based science and value-free science is drawn by Lincoln and Guba (1985) in their analysis of the postivist-naturalist paradigm:

Positivism excludes the 'context of discovery' and focuses on a 'context of justification'. Verification has taken precedence over discovery... because discovery has avoided a systematic approach.

(Lincoln and Guba, 1985, p. 25)

Lincoln and Guba's (1985) paradigm (Table 3), adds to the argument for a cross-disciplinary and multidimensional science rather than a unidisciplinary, dichotimized research that claims sanity, i.e. to be free of values.

The comparison between psychiatric, educational, and Indian investigation is evidence of different forms of human enquiry. Once more, each is bound by values, beliefs and assumptions.
Table 3. Contrasting positivist and naturalist axioms (Lincoln and Guba, 1985, p. 37)

<table>
<thead>
<tr>
<th>Axioms About</th>
<th>Positivist Paradigm</th>
<th>Naturalist Paradigm</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nature of reality</td>
<td>Reality is single, tangible, and fragmentable.</td>
<td>Realities are multiple, constructed, and holistic.</td>
</tr>
<tr>
<td>The relationship of knower to the known</td>
<td>Knower and known are independent, a dualism.</td>
<td>Knower and known are interactive, inseparable.</td>
</tr>
<tr>
<td>The possibility of generalization</td>
<td>Time- and context-free generalizations (nomothetic statements) are possible.</td>
<td>Only time- and context-bound working hypotheses (idiographic statements) are possible.</td>
</tr>
<tr>
<td>The possibility of causal linkages</td>
<td>There are real causes, temporally precedent to or simultaneous with their effects.</td>
<td>All entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects.</td>
</tr>
<tr>
<td>The role of values</td>
<td>Inquiry is value-free.</td>
<td>Inquiry is value-bound.</td>
</tr>
</tbody>
</table>
The task identified in Table 3 is one of discovering how various sorts of meaning work, not to pronounce one sort meaningless and the other sort true. Polanyi (1958) viewed complete objectivity "as usually attributed to the exact sciences is a delusion and is in fact a false ideal" (p. 18) and called for a re-valuation of science:

The urge to understand experience, together with the language referring to experience, is clearly an extension of this primordial striving for intellectual control. The shaping of our conceptions is impelled to move from obscurity to clarity and from incoherence to comprehension, by an intellectual discomfort similar to that by which our eyes are impelled to make clear and coherent the things we see. In both cases we pick out clues which seem to suggest a context in which they make sense as its subsidiary particulars.

(Polanyi, 1958, p. 100-101)

When the process of knowing and changing occur simultaneously, as could be expected in long-term studies, researchers must face a dilemma. If the situation under study undergoes changes by the process of the study, then what is finally studied must be something different from what was originally intended. When dialogue becomes part of the inquiry, (Lincoln and Guba, 1985), and when intervention presents this dilemma (Dhar, Tandon, Pandey, 1987; Shor and Freire, 1987), the dialogue generates both understanding and
change (Tandon, 1981). It is in this context which Tandon argues that because there is an impact on people, the "value-neutrality of the researcher is a myth" (p. 300).

The common experience of people who use mental health services is how they are treated (Chamberlin, 1979; Oliver, 1990; Anthony, 1991), not how they are as a schizophrenic, for instance. A cultural development of knowing what is valid is invariably contentious, for example between the mental health service provider and the user of mental health services (Chamberlin, 1979).

A number of scholars have called for deeper, more meaningful explanation of scientific issues (Polanyi, 1958; Miller, 1975; Lemaire, 1977; Elton and Laurillard, 1978; Harding, 1985). Explanation of phenomena can be incoherent with the meaning of individual people who are subjects of research.

No matter how different-looking or submerged in culture a person is, regardless of the values they exude, s/he is, today, more often considered capable of looking critically at the world. Within a
constructivist approach (Kelly, 1955), there is also a cross-disciplinary assumption of personal change (Thomas and Harri-Augstein, 1985; O'Brien and Lyle, 1987; Dunnett, 1988; Watts, 1988; Bernstein, 1988). The relative absence of personal understanding in mental health care research has led to a plethora of criticism about conventional methods (Wertheimer, 1989). It is as though the thing that a percipient sees must be lost if it is to be represented.

Apart from the seepage through scientific method of personal meaning, a loss of individual understanding is a part of the reconstruction of knowing (Lemaire, 1977):

'I am what I think', therefore I am: divide the 'I am' of existence from the 'I am' of meaning. This splitting must be taken as being principle, and as the first outline of primal repression, which, as we know, establishes the unconscious.

(Lacan's Ecrits, in Lemaire, 1977, p. 77)

The notion of personal knowledge as constructs within the individual that are managed within but yet influence personal knowing outside, was identified by Freud (Strachey et al., 1967) as he came upon the mechanisms of defence and symptom formation through the interpretative decoding of dream texts:
The transformation of the latent dream-thoughts into the manifest dream-content deserves all our attention, since it is the first instance known to us of psychical material being changed over from one mode of expression to another, from a mode of expression which is immediately intelligible to us to another which we can only come to understand with the help of guidance and effort, though it too must be recognized as a function of our mental activity.

(Freud 5:642, 1900-01, in Strachey et al., 1967)

Reflective power is in a sense disposable knowledge as the process of construing involves reconstruing. All the more important to take account of meaning, such that it is. Reflection, rather than knowledge or meaning in stasis, would be the mechanism whose framework and substance replaces itself in the process of reconstruing, that is, changing. The supposition is that the different self-inventings—ways of getting through the personal process by discovery—conscious and unconscious, are at an advantage in the context of another person's construing. In the course of revealing how the world is seen, the construct of both personal investigators is effected, that is, changed. If this is the case, a fixed method of research could miss the meaning of many ordinary and practical human experiences, by not accounting for how they were construed or to what extent the constructed view has changed the meaning of a subject's evidence. This
metaview would appear to be a natural product of the relation between positivism on the one hand and linguistic philosophy on the other (Williams, 1982). Such a thinking-through of paradigmatic issues continues to point-out a unity in scientific method rather than a dichotomy of concepts.

A re-valuation of scientific method, through the exploration of self-discovery and personal care in the mental health field, would be directed at a study of opportunities for constructive activity. The research will entail an examination of whether joint understanding of words and things is, in fact, a practical reality. Polanyi's rationale for such a research focus is that:

we can never learn to speak except by learning to know what is meant by speech. So that even while our thoughts are of things and not of language, we are aware of language in all our thinking (so far as our thinking surpasses that of the animals) and can neither have these thoughts without language, nor understand language without understanding the things to which we attend in such thoughts.

(Polanyi, 1958, p. 101)

A method of research which did not account for aspects of construing may themselves misconstrue what the data meant, particularly in the process of removing what is thought to be known in a response to a question and
transforming that to a set of findings. In Polanyi's terms, objectivism requires a "specifiably functioning mindless knower" (p. 264). If this is the case, personal knowledge is erected in a unique idiom of human experience where individual systems are constructed to articulate values, beliefs and convictions.

However, much of the literature in Chapter One denies, in effect, the existence of validity in this construing, vis-a-vis a permanent or fixed amount or definable quality of replicable knowledge. This demand for certainty in mental health care must be, in outcome, the equivalent of the deadening circularity of construing and knowing—this is indicated in the studies within mental institutions by Barton (1976) and Goffman (1961).

**Getting to Know**

A critical examination of the literature reveals that professional hypotheses, as do personal theories, anticipate outcomes. From the previous chapter, my own experience with mental patients and my conversations and collaborations with them indicates that how we came to know and gain knowledge could only
occur by us, in that way, together, i.e. in a context where we were opened to the experimental testing-out of each other. The notion from practice of the person as a research method is conveyed in a philosophical context by Polanyi (1958):

To say that the discovery of objective truth in science consists in the apprehension of a rationality which commands our respect and arouses our contemplative admiration; that such discovery, while using the experience of our senses as clues, transcends this experience by embracing the vision of a reality beyond the impression of our senses, a vision which speaks for itself in guiding us to an ever deeper understanding of reality -- such an account of scientific procedure would be generally shrugged aside as out-dated Platonism: a piece of mystery-mongering unworthy of an enlightened age. Yet it is precisely on this conception of objectivity that I wish to insist...(p.6). Into every act of knowing there enters a passionate contribution of the person knowing what is known, and...this coefficient is no mere imperfection but a vital component of his knowledge (p. viii).

Polanyi (1958, pp. viii-6)

The effect of such reasoning is more than a matter of level of abstraction in the discussion of scientific endeavour. Subsumed into the notion of first principles that value methods of practice experience and practice knowledge is that the questions involved in research have personal meaning and significance for the researcher. Scientific issues are manifest within the researcher, they are part of his personal constructions (Bannister, 1981). The major
significance of the personal dimension of research is a shift to valuing that meaningful constructs distinguish the world of each 'subject'. A specific implication for educational research method is the impetus for the subject to be encouraged to investigate further by himself.

Research method is complicated by the extent to which the personal aims of staff and service users interact with clinical intervention and professional investigations (Cullen, 1990; Bloch and Harari, 1990). Being a philosopher rather than a psychiatrist, Bernstein (1988) sees more than a challenge among determinates to method; he calls for an intense scrutiny of the 'tyranny of method' (p. xi) that constrains modern inquiry in human science.

Research reviewed in the literature represents studies of the way people categorize. In Lakoff's (1987) terms, scientific method can be seen as involving "the manipulation of abstract symbols which are given meaning only via conventional correspondences with things in the external world..." (p. xiii). Those correspondences have to be found after the categorization is made implicit in the research methodology. Using that method as a mechanism to
understand the reasoning of research participants, the subjects of prior research, to the people of the present research, it "means devaluing intelligence" (Lakoff, 1987, p.xvi).

The literature in the opening chapter reveals a methodological dilemma in mental health care research. The demand for scientific method to possess determinate, fixed criteria is applied when repeated results indicate insufficient homogeneity to substantiate such preset procedure. To address the relative absence of personal research in this field, and to explore the contribution of the investigated people, the present study now examines philosophical issues.

The method of the present study lacks innocence and neutrality as did the prior research before it. However, given the deficits of bias and accounting for them with methodological safeguards, personal research is viewed as an investigation of educational opportunity for human accomplishment in mental health care.
Philosophy of Human Science

The present research 'enters' the debate between the natural and social sciences at a curious point. In their expansive studies of the rationality of method in the sciences, Lakoff (1987) and Bernstein (1988) raise questions about the way that the use of category contaminates research method with pre-eminent distinctions and biases. Methodology has always been informed by investigators prior knowledge and orientation to research. The disputed point is the extent to which this process predetermines outcome.

There is an anxiety amongst researchers about the possibility of chaos, madness, or dread, if nothing is fixed. Bernstein's (1988) study refers to the Cartesian Anxiety:

Either there is some support for our being, a fixed foundation for our knowledge, or we cannot escape the forces of darkness that envelop us with madness, with intellectual and moral chaos.

(Bernstein, 1988, p.18)

Madness, as such, is another dimension to the anxiety of science. Chapter One demonstrates, in mental health care research, the standardization of human distress, ready for generalization. The Cartesian Anxiety has a poignant affinity to the present study,
where there is a real experience of chaos by patients whose reality is contested by the dominant anxiety, guided by 'natural' science. If patients are moved out of hospital, as they are, placed in a neighborhood and with people they may or may not know, and are expected to lead a life, what is the nature of an enquiry that seeks to discover how individuals may be supported in their quest, now the hospital environment has been removed?

Two Australian psychiatrists have found, in their research of family therapy, that the power in helping people resides in the ability of practitioners to:

- fashion new narratives which lead to the dissolution of the problem by altering the meaning of people's behaviours which have been organized by the problem.

(Bloch and Harari, 1990, p. 306)

The objective dimension of scientific method avoids personal entanglement, as Mair (1990) puts it, but 'the outcome is known before the story is even begun in a public way.' Mair elaborates the concern of earlier personal construct theorists that the manner of telling speaks of how knowing is to be understood and of what is to be known. This, Mair (1990) argues, is a 'very different perspective on knowing
and knowledge from the standard approaches in empirical psychology.'

The assumed question about the invalidity of personal knowing is embedded in the literature as non-sequitur: the conclusion that scientific method is free of values, or that objectivity is based upon that premise, does not logically follow from either the review of prior research in the field or of philosophical issues.

In effect, there is a shift in attention, from events to relations. This has happened in a number of the sciences in the past half century and was well expressed in Elton and Laurillard's (1978) reference to Russell:

The traditional conception of cause and effect is one which modern science shows to be quite fundamentally erroneous, and requiring to be replaced by a quite different notion, that of laws of change.

(Russell, 1921, p. 23, in Elton and Laurillard, 1978)

This shift, and the present research in self-discovery, goes to greater depths when considered in the language of mental illness. The deepest experience of language can be found in madness,
According to Lecercle (1985):

The subject is always fighting for mastery, always trying to be as an instrument that which carries him like a stream, always trying to appropriate the world through the word, to name things, to give them order through syntax and narration -- this attempt is bound to fail and to be forever repeated, because of the contradiction inherent in the relation between language and reality, words and things.

(Lecercle, 1985, p. 31)

In Lacan's study of neurotic and psychotic experiences, the understanding of an individual's experience is also found in the person, not the illness (Lemaire, 1977). By naming a thing, and with this name giving it the value of a concept which may be used without direct reference to that thing, this naming has the effect of giving a person their individuality; by naming in this way the person is delivered from the alienating trapping of the imaginary:

Just as it has been said that the word brings about the murder of a thing, and that the thing must be lost if it is to be represented, so the subject loses himself in his truth or his reality by naming himself in his discourse and by being named by the speech of the other.

(Lemaire, 1977, p. 77)

Cause-effect relations are closely connected to the thema of hierarchial structures, and the wish to find
them is ancient (Elton, 1977). If by naming a thing a person is distanced from it, as suggested by Polayni (1958), Friere (1972, 1973), Lemaire (1977), Lecercle (1985), there would be changes in the experience of the person that might have been missed by the individual himself or by the scientist abstracting his experience. If knowledge arose from within conduct, insofar as the context of action and artifacts of language were examined (Austin, 1975; Heath, 1985; Jaeger and Rosnow, 1988), the incipient empirical methods of the mental patient would be contradicted -- would, in Freire's (1973) terms, naturally come into conflict with the technical "significata" of the agronomists (p. 142). Abstract language, or abstracting the assumed message of a person from its physical or material origins, would be to put what was named into another, a different, system.

Material language, as Lecercle (1985) calls it:

is unsystematic, a series of noises, private to individual speakers, not meant to promote communication, and therefore self-contradictory, 'impossible' like all 'private languages', it is an integral part of the speaker's body, an outward expression of its drives. It imposes itself on the individual, controlling the 'subject'...language which reverts to its origin in the human body, where the primary order reigns.

(Lecercle, 1985, p. 44)
Methodological Argument: A Choice of Approach

Least evident in the literature is an understanding of mental health care, from the participants' points of view, i.e. from direct-care staff who provide a service and people who receive it. In particular, the evidence circumvents a central question that it promotes: whose view of knowledge is real? Such a rhetorical question belies the implications of avoiding it. From a cross-disciplinary point of view, there is merit in exploring whether it is necessary to 'hold' that any view of knowledge represents 'reality', given the foregoing analysis.

Different approaches to research appear to create dissimilar outcomes, as if, on the surface, there is no commonality in scientific terms. An example is the gap between participatory educational researchers, e.g. Shor and Freire (1987), Law (1988), Faundez (1988), and psychiatric researchers, e.g. Vaughn and others (1982), Gubman and Tessler (1987). However, the former could be referred to as the paradigmatic dimension of scientific method and the latter as the conceptual 'face' of research science. The one links to the other by a synergy of personal knowledge with objective knowledge.
Rose and Black (1985), who use the participatory research approach to education in the field of mental health care, substantiate the claim of personal researchers, viz. that the expression of individual knowledge and experience is vital to growth and learning. The concept of androgogy in adult education is built on this assumption (Knowles, 1984).

Freire (1973) argues that:

since the pedagogical problem is a gnosiological condition in which the knowable object is the existenital situation represented in it, it is not the role of educators to narrate to the educatees what in their opinion constitutes their knowledge of reality or of the technical dimension involved in it. On the contrary, their task is to challenge the peasants once again to penetrate the significance of the thematic content with which they are confronted.

(Freire, 1973, p. 161)

The corpus of Freire's work (Freire, 1972, 1973, 1985) and that of his proteges, e.g. Tandon (1981), Hall (1981), Horton (1983), is focussed upon the people whose educational prospects are diminished in relation to the differentness of the 'alienating character of the everyday' (Freire, 1985, p. 157). Thus, the existential position of man has its genesis, such that:
Our committed, but nonneutral attitude toward the reality we are trying to know must first render knowledge as a process involving an action and reflection of man in the world... We cannot remain ethically indifferent to the fate that may be imposed on our findings by those who have the power of decisions, but merely yield to science and its interests and subsequently dictate their aims to the majority.

(Freire, 1985, p. 112)

A generative idea in pioneering family role play was that during replay both family members and therapists became data researchers in a process which helps to change the roles of both (Heilveil, 1983). Participants became equally involved in reviewing and reacting. Heilveil (1983) found that this process fostered mutuality and was "more of a human adventure" (p. 101). Lincoln and Guba's (1985) notion of a naturalistic paradigm is that the focus of research alters as new information makes it relevant to do so -- "such changes signal movement to a more sophisticated and insightful level of inquiry" (p. 255). If the substantive theory to guide the inquiry is based on the values of personal knowledge and experience, then the research paradigm must be adaptative and accommodating.

If the data of a paradigm is based on language used, and if the meaning of the words is assessed by the
word-users, then it must be understood that the meaning conveyed in terms of the research outcome could be no more than the previously acquired meaning of individuals involved. Far from being a limitation to validation, the paradigm is nevertheless a different language.

In Polanyi's (1958) terms, personal participation is:

greater in validation than in verification.
The emotional coefficient of assertion is intensified as we pass from the sciences to the neighboring domains of thought. But both verification and validation are everywhere an acknowledgement of a commitment; they claim the presence of something real and external to the speaker. As distinct from both of these, subjective experiences can only be said to be authentic, and authenticity does not involve a commitment in the sense in which both verification and validation do.

(Polanyi, 1958, p. 202)

Therefore, the paradigm itself becomes the subject of investigation. The outcome of research will be more concerned with the issue of its methods than the generalization of individual's data. However, as Tandon (1981) found, when the process of knowing and changing occur simultaneously, researchers face a dilemma:
If the situation under study undergoes changes by the process of the study, then what is finally studied is something different from what was originally intended. Dialogue as inquiry and intervention presents this dilemma. The dialogue generates both understanding and change. To that extent it contaminates the situation it purports to study.

(Tandon, 1981, p. 301)

The notion that action occurs, and that it is the main concept in knowing, is supported by Wells (1985). The process of construing reality changes the percipient and changes the reality perceived (Wells, 1985). There are then two major features of study in this paradigm. One is the personal research of the construing participant. The second is the method of research in the paradigm. And thirdly, there is the question of the relation between self-discovery and personal care.

The literature review suggests that the form of reasoning appropriate to a practical science like mental health care is praxis. In their review of curriculum research and teacher professionalism, Carr and Kemmis (1986) define it as:
informed action which, by reflection on its character and consequences, reflexively changes the 'knowledge-base' which informs it. Where poietike is 'making-action', praxis is 'doing-action'.

(Carr and Kemmis, 1986, p. 33)

The context of this construction of coming to know is therefore dialectical, because the reflective-action creates an opposition of a thesis against its antitheses, with a new synthesis being arrived at. The Kellyan (1955) view is that the possibility of the student's hypothesis being invalidated opens the door to other alternatives by:

Finding better ways to help a person reconstrue his life so that he need not be the victim of his past.

(Kelly, 1955, p. 23)

Research paradigms are thus subject to a complex of beliefs, values and assumptions of the percipient researcher. For example, remission is inevitable in schizophrenia, or psychiatric hospital patients are less valued than people who are not mentally ill, or individuals can develop and grow, regardless of their disability.

The paradigm of the present research differs from the initiation of positivist researchers, who experience
"prescribed and settled ways of thinking that are transmitted across generations of researchers" (Carr and Kemmis, 1986, p. 74). However, the choice of approach for the present research evolves from the pluralism of approaches in transition, as seen in the review of literature, to an inevitable cross-disciplinary study that is tightly focussed upon a case in point.

A Summary in Anticipation of Research

Knowledge is validated by exposing the theoretical context that defines practice to the self-reflection of participants in the research study. As a study in educational science, the present research could be seen to neglect questions about the origins, causes and results of what people do--these being areas of interest to studies in natural science. However, the present study aims to establish a place for its paradigm in the relationship of theory to practice, filling a gap in the common dichotomy all too often cited when comparing natural and social science research.

From a researcher's point of view, the educational question that arises in the transition from mental
hospital to community-based care constitutes a useful challenge to the adequacy of a constructivist paradigm. Will the paradigm improve the practical effectiveness of the theories that the practitioner employs in thinking about and doing activities? The investigative paradigm strikes an analogy between the researcher-teacher, student-staff members and client 'subjects' and a hypothesized method for learning that is implicit in self-discovery.

A teacher, no more or less so than a student, cannot enter their field as a researcher in an unprejudiced manner, when they already live and work in it. There is no pretence about bias in the chosen approach to research. It is driven by values. An example is: care rather than custody defines a helping strategy, much the same as it does an educational strategy.

Compared with participatory research, where participants can be patients or migrant farmers, for example, there is a significant difference in who can use research and to whom the research is relevant. This difference is not a shift in the way of explaining how people get to know and what they do as the result of that learning. The assumption in the academic/correctionist literature is that both
symptoms of mental illness and prognosis govern how people function, i.e. in a disabled manner that is subject to remission.

If there are three types of knowledge being suggested, i.e. professional knowledge, personal constructs, and practical experience, an attempt at analysis of data must be limiting. From the researcher's point of view all three may be acquired and integrated during initiation into a research culture. The Freirean purist would, no doubt, experience a sense of accomplishment, then, as the result of his disempowerment, in refusing to set the authority of conventional design upon what the conventionalist would call a sample population. His initiation, however, is as much designed to benefit his practice as the initiation of any ideologised discipline would require. So, there may be little difference in the ambition of the participatory researcher to that of the psychiatric researcher. The outcomes will have alternative contributions to the knowledge base, however it has been internalised by the researcher and projected onto the design for study.

If the argument in the analysis of the foregoing chapters is true, that method is not neutral, or
value-free, then what is the effect upon the outcome of research if method does not presuppose an understanding of, and therefore shaping of, the outcome?

The evidence of the foregoing chapters portray method as anything but innocent or neutral. Method, as a legacy of scientific tradition or as research artifact, is, however, the manner of reconstruction in science upon which turns the value of practical criteria and standards, e.g. of care, when the data is applied.

Following from the literature, from a researcher's prior knowledge and experience, from a philosophic analysis of 'the manner' of a constructivist enquiry, from a study of moral conduct in the ethics chapter to follow, something is wrong with the ways in which the relevant issues and options are posed, when examined in the context of the present research. The more ardent personal construct theorists would point to this as another example of 'miss-take' in the experimental career of hypothesizing 'man' (Kenny, 1988; Dunnett, 1988). In the absence of consensus or homogeneity, research method cannot be a mechanism for making data replicable in the present field of study.
ETHICAL DILEMMAS

There is something wrong with research in the way relevant issues and options are posed (Bernstein, 1988; Mair, 1988; Hunt, 1989; Cullen, 1990). The foregoing chapters have pointed to personal and moral aspects of science as neglected dimensions, and in mental health care the individual meaning of research 'subjects' data provides a case in point for healthy scepticism of traditional investigative method. How is it that research can be seen to be wrong?

Two issues emerge from the literature review to address the question. First, there is a discovery of diversity of opinion about what is right and good about mental health research. It emerges from a convergence in the late 20th Century of various disciplines to inter-disciplinary and inter-agency interest. Truth, as it were, may no longer be conceivable as absolute and singular but multiple, and in the examination of this thesis multi-dimensional.
Secondly, there is an emergence of subjective knowing in research, not dissimilar from the central developmental enquiry of adolescence (Erikson, 1968). What is 'wrong' with research is the absence of an adherence to the knowledge within people, that binds and directs their life. An investigation that is cross-disciplinary will, therefore, identify incoherent qualities in research that fail to account for empirical assimilation of subjective knowing.

The extent to which personal and service ideologies interact with clinical intervention in order to bring about this state of affairs has come under intensified scrutiny, with challenges to both ideology and interventions (Cullen, 1990). The evolving amalgamation of interdisciplinary interest is credit to the supposition that people with mental illness need the help of others, to a greater or lesser degree, in order to do more for themselves to be fully engaged members of communities, neighbourhoods and the wider society.

That mental health care is a case in point to examine scientific method and the question of self-discovery is due to its 'position' on the boundary of various
disciplines and ideologies. While it is significant that ethical principle is an area where cross-disciplinary unity is expressed, applied research methodology continues to be debated.

Mair (1990) refers to an 'emerging moral science of persons' whose evidence is 'crippled' by research constraints, when the 'border guards of conventional authority' react to the methodological pursuit of individuality in the data. Using 'psychiatry' as a field example, Berg and Smith (1988) submit that far from being constrained, the relationship between investigator and the investigated people should be central to the quality of the research. Perry (1988) argues that it should not be surprising, whether in psychiatry or physics, that researchers should find themselves as participants in their observations of human endeavour. However, the antithetical notion of the centrality of relationships in research raises significant ethical questions, to be addressed in three sections of this chapter: Ethical Principles, Problems in Establishing Methodology, and Difficulty in Means of Analysis.
A basic assumption of the present research is that it is ethical, insofar as the duty of any scientist is to expand human knowledge through research, such that it provides humans with greater understanding and control in their lives. The analysis of foregoing chapters supports the investigation of a constructivist approach in a context in which self-discovery might be useful. Furthermore, given the analysis of literary evidence it would be unfair to avoid investigating a constructivist approach. Denying the potential of an alternative approach may be detrimental to a group of research participants and to multi-disciplinary interest in this field. The possibility of an investigative approach that provides an interface, between values-based practice in the disciplines and conventional research in the professions, stands to gain, as well as participants who may gain experience of themselves in the research process. However, another question that is part of the overview of ethics is the extent to which application of knowledge gained in research may be applied in unethical ways to the detriment of society or groups within society. For example, there is concern that a growing business perspective views health care as a commodity and the ethical obligation of a professional as becoming that of businessman to consumer (Nadelson, 1991).
Ethical Principles

In psychiatry (Winston, 1990; Westmore, 1990), in psychology (Steere, 1984), and in nursing (Tschudin, 1986), there is a unity of concern that the principles are respect for the individual, confidentiality, informed consent, beneficence and non-maleficence, and fairness. Although a formal reference to ethics is absent in the new Code of Practice (Department of Health, 1990), a consensus to principles is evident. People being assessed for possible compulsory admission to a mental health service should, for example:

receive respect for and consideration of their individual qualities and diverse backgrounds...
be delivered any necessary treatment or care in the least controlled and segregated facilities practicable...be treated or cared for in such a way that promotes to the greatest practicable degree, their self determination and personal responsibility consistent with their needs and wishes.

Dept. of Health and Welsh Office (1990, p. 1)

Furthermore, individuals should be 'as fully involved as practicable, consistent with their needs and wishes, in the formulation and delivery of their care and treatment, and that, where linguistic and sensory difficulties impede such involvement reasonable steps should be taken to attempt to overcome them.'
Although it is agreed that the operative principle for informed consent is respect for the individual's autonomy, there are other variations on the theme. Elliott and Gunderman (1990) refer to the:

right to self-determination of competent adults, and the belief that [psychiatric] subjects themselves are best able to determine in what direction their interests lie.

Elliott and Gunderman, 1990, p. 664)

Steere (1984), a clinical psychologist, refers to the irreconcilable contradiction between the concepts of authority and autonomy:

because the principle of autonomy dictates that individual choices should be made completely unimpeded by the influence of any authority... this is not necessarily so because in most democratic social systems governing bodies are autonomously chosen and therefore the decision to obey authority is itself autonomous.

(Steere, 1984, p. 7)

Thus, professionals have authority by virtue of their specialized knowledge. Their clients right to autonomy is to a certain extent a function of their awareness of that counterplay, as it is mediated by their research purpose. However innocent, coercion
may be inevitable as the best interests are decided and promoted by the people who are paid to do so, corrupting the concept of informed choice.

Not harming people involved in research, non-maleficence, and contributing to their health and welfare, beneficence, further define a framework for the 'rules' of ethical research. Given the constraints of authority upon informed choice, there must be a question whether researchers can be 'free' to give attention to the principles of non-maleficence and beneficence, such that their investigation allows subjects 'moral space' (Kitwood, 1990).

**Ethical Issues in Field Relations**

**The Process of Permission**

The time of assessing for permission to participate in research was prolonged and unending. The researcher's approach to consent is informed by a sensitivity to patient's evidence (Chamberlin, 1979; Oliver 1990; Anthony, 1991), their experience in a historical context (Chapter One), and by his personal knowledge of their disadvantage in field relations (Chapter Two). The effect of an approach to continuous assessment of permission inevitably led to a
self-selection procedure whereby patients and staff could opt in or out of participation during the research. This condition was a principal safeguard, given the dependent status of patients, and in some cases of staff, in mental hospital for a number of years.

The first three houses 'opened' in sequence during 1989. The investigation of a constructivist approach to self-discovery in the first year post-hospital cohort began with the literature research in 1987-1988. The format for signed consent was a contract that allowed all participants to select to opt-in or opt-out of the study at any time (Appendix I).

This form of consent was developed in consideration of the way in which the research was integrated into the design of the new supported housing project, emerging with the project as it became people and houses in the local community. Permission was sought in a formal way once the new houses opened, after the process was piloted.

Prior to the opening of houses, I became researcher to the project teams during the hospital planning
stages of transition to community-based care. This process emmanated from the 1987 post-graduate research agreement struck between the University, the Health Authority, and myself, that the research would be related to my job as staff development tutor and educational advisor. Further to the collaborative agreement, permission was agreed prior to June 1988 in the multidisciplinary management team with operational responsibilities for transition to the new staff-supported houses.

The first, January 1989, house project, 'entered' the piloting stage of research before and during the opening, prior to the beginning of primary research in June 1989. Piloting of the video-recording data-collection procedure (Appendix II), which had begun in June, 1988, was integrated into the assessment for consent as the staff, first, and then the patients, were named for the initial residential care project.

Researcher and prospective participants, therefore, were assimilated into the planning structure for project development, which, for example, included
staff team meetings, and later project 'teas' with patients. This process repeated itself as the second and third house projects came 'on stream' prior to their opening in July 1989.

That the contracts for consent are discussed in the following chapter, which examines the procedural aspects of methodology, underscores the emphasis in the research design to examine and assess permission ahead of the actual asking. Given the long-term nature of patients' hospitalisation, the nature of change for the whole cohort, and the use of video-recording for data collection, a short-term process was inappropriate.

Application of Method

The employment of research methods was preceded by a prolonged period of participation in the development of the supported housing project. The researcher was educational advisor for Continuing Care, an organisational sub-group in the health authority which incorporated the new project. The initial period of the project allowed for the development of rapport with staff and patients to ensure that if the research was to proceed it would be built upon the constructs
of personal trust and self-selection. At the same time the literature research was in progress.

This period, before the pilot study, also ensured that the researcher, in addition to his prior research and practice in the same hospital, became familiar with the new context of research. Hunt (1989) refers to entry procedure that familiarises and integrates the researcher as being essential to formulate 'culturally relevant questions based on understanding native meaning structures rather than a priori assumptions' (Hunt, 1989, p. 13). The importance of native meaning structures is discussed in Chapter Two.

The researcher created the conditions for self-selection in a dialectical contract for permission to participate in the research (Appendix I). As with all of the instruments in the research project, the consent form was presented orally and discussed, leaving the activity as a template through which the researcher and participants might experience any signal of moral violation. During the assessment for video-recording (Appendix II) there was added opportunity to ask for and detect the extent of intrusiveness. The health authority ethics committee, which had approved the procedures, also required that
the forms be signed and that in addition permission be video-recorded. Emphasis upon choice in participation was to give credence to the video-taped data. Participants could take part in the research without being video-taped. The degree of trust and rapport with the researcher would be the prelude to individual and mutual assessment, e.g. a participant's hesitancy would more likely be recognised and respected by the present researcher than by a purposeful stranger. Therefore, the ethical considerations limit the extent of which investigative method can predetermine how the research can be finally fixed, to proceed in a static way, across a field in which variables are in check. Ethical constraints are, where people are research subjects, safeguards with respect to a sensitivity to and sensibility for the knowledge and experience of participants -- in this case former hospital patients and their staff.

Testing Out the Implications

By comparing cross-disciplinary research in previous chapters, the nature of evidence, or data, is seen to vary depending upon the assumptions, values, and beliefs of the researcher's profession and by the adopted methodology. The intention of the present
research, rather than to separate or dichotomize the empirical and practical basis of helping people, or to 'prove' a hypothesis, is to test whether an approach to research that values and believes in the participants' personal evidence can enhance understanding and knowledge in mental health care.

First the Literature Review and then Chapter Two identified an omission in prior research of eliciting direct evidence from patients -- evidence that is ethically suspect. The convention was to supply constructs upon which methods for finding-out were devised. Prior studies tended to focus upon preset outcome measures such as the degree of recidivism or changes in levels of social functioning or clinical symptoms. The analogy in Chapter Two between hospital life and community living, heightens the question of the researcher as a stranger. In addressing these anomalies, the present research examines the moral and personal dimension of scientific enquiry, by testing methodology derived from a cross-disciplinary knowledge base and applying it to the question of self-discovery.

Unearthing these points, a moral foundation is constructed to a methodological hypothesis. For the
data of patients to be taken at face value, the methodology of prior studies would have had to be different. That there was no defence in these studies of both the choice of items and the weighting accorded to them, signifies that direct patient data is less relevant, less useful, and less valued than the judgements of staff and researcher informants (Norman and Parker, 1990). In such cases, Jones and Fowles (1984) claim that what appears to be a reliable and objective measurement often turns out to be both subjective and unreliable.

Problems of Establishing Appropriate Methodology

Because the research is an alternative approach it operates with an ulterior motive: it defends against a uni-professional stance in the literature, which claims, in the main, that the lone measure of reality, knowledge, and truth is an objective one. An observer could be forgiven on examining some literature for thinking that when values enter research, they must be dismissed as being subjective or emotional aspects of pseudo-knowledge.

The subjective-objective debate is a narrow and misleading dichotomy. On the evidence thus far in the
present research, it avoids the conception of science being multi-dimensional in methodological design as well as in life forms and it denies access to scientific endeavour by the investigated people.

The elements of change in mental health care and the helping of people with emotional difficulties has led non-psychiatric investigators with a clinical interest to conclude that a moral science is emerging (Mair, 1990). Personal construct psychologists equate living and learning in a process of questing or human becoming, rather than just being (Kenny, 1988). This is a moral issue insofar as there is a question of whether people are free to engage in personal changing, discovering, challenging, helping and sustaining of themselves in the context of changes and challenges by the mental health service. Persons inevitably 'lose rights' as 'the engines of orthodoxy' take preference (Mair, 1988).

Problems with the methodology will be direct involvement in the first-hand research experience by the researcher. Despite the triangulated procedures for data collection and a testing-out approach to constructivist research, the question is raised of the interpretative fairness in the study. From a personal
construct viewpoint, the concept of fairness in data interpretation would be evident in the method of analysis of a construing field, e.g. the residential care houses.

At the risk of undue intrusion, the logic of self-reflection in participant observation is a consequence of direct involvement, to the end of studying the theoretical and practical opportunities for self-discovery and personal care. Apparent in Chapter Two is the need in theory and practice to match criteria, in this case, the reflectiveness of the practitioner, the researcher, the educator. However, the extent to which this study is changeable, its heuristic nature, presents a problem of coherency in the context of orthodox research.

Ethics is understood less by the personal and moral knowledge and experience of subjects than by research concerned about the force of institutional change, change in environments, methodological replication and advance, and socio-economic implications of change. Institutional change and the subsequent research arena
is changing by virtue of moving psychiatric hospital patients into local community care, and changing the National Health Service role from provider to supplier of treatment and care (Department of Health, 1989; Secretaries of State for Health, Social Security, Wales and Scotland, 1989; Knapp et al., 1990).

What researchers had done in hospital investigations was attempted in community environments. A review of this literature demonstrates the gaps that arise in using formal conventions in an informal environment. Nevertheless, in the main, the data taken is taken in much the same way regardless of these changes.

Perhaps nothing would be said about this if not for the questions raised by comparing traditional research in mental health care with the move toward consumer satisfaction (Department of Health, 1989), demands for better quality services (Secretaries of State for Health, Social Security, Wales and Scotland, 1989) and the advance of clinicians and educators in studying human services from a personal, constructivist, point of view. Personal construct psychologists, and sociologists involved in normalization, have in common a focus upon the values and beliefs of people who use and deliver mental health services. From an ethical
perspective of this field, personal research represents a moral dimension of scientific method. If each life cannot be replicated, by experiment or otherwise, and if individuals are unique, then the data they produce is distinguishable and discrete. The present study, in the context of mental health, is a constructivist approach to the science of the self, of the person, of their questing. In ethical terms, it enters a gap between the Is and the Oughts, and seeks an investigative method for the former.

A synthesis of this evidence provides a testable question for the research at-hand, problematic as it is, because it forms the basis for moving beyond the subjective-objective dichotomy of impersonal approaches to research and practice. If there is a moral dimension to scientific method, how is it expressed in the practice of research? In a domain of clinical work, what can be learned by investigating a personal approach to a contribution that involves the knowledge of ex-psychiatric patients and their care staff? What opportunities for equity in research are evident as people are 'becoming', in their new living and working arrangements outside hospital?
There is a particular problem in the expressed difference between the world of the hospitalized mental patient moved into the community and the world of objective knowledge and method. The gap in this continuum of experience is populated with the present research participants, living and working in houses operated by a mental health service. The methodological problems of testing-out research is compounded by its basis in personal values and the investigation of personal criteria, i.e. of a constructivist approach and of self-discovery. However, an enquiry about the relevance and utility of being personal has implications for the identified human and moral dimension of science and for subsequent contributions of data-givers to data-collectors.

In ethical terms, the present thesis argues that, at the core, mental health care research faces a constructivist challenge of choosing whether to represent the views of professionals in its methodology or choosing whether to find a way for direct access of service users' views, succumbing to the challenge of ethical constraints upon methodology that may entail.
Linkages between existing multi-disciplinary research and theoretical perspectives community health care provide a basis for a constructivist approach that is focussed upon self-discovery. Existing values about the conduct and method of research, therefore, inform guide, and justify the present research.

If a constructivist approach has a moral basis, in its belief in valuing personal knowledge and experience regardless of individual circumstances, ethical issues may include the extent to which the research may or may not undermine (i) the security of staff or residents, and (ii) the credibility of practice or management in the mental health service.

A philosophical study of moral concepts in the present research is bound to ask the questions, 'Who are the people? What caused the problem? What ought to happen to them?' Because there are many answers to the second question, the answers to the third question vary in a significant way. The significance is not so much in what the answer is, but that it depends upon the beliefs of the person answering the question. In this way, an investigation of a constructivist approach to self-discovery must be personally challenging.
An attempt will need to be made to minimise unfairness and lack of respect for individuals by valuing their evidence in the personal context in which their data is given. However, the literature research amongst the disciplines reveals that a constructivist approach goes beyond constructs that are personal structures emanating from each hypothesis-testing person. The theoretical connections imply an ever-changing fabric of constructs 'outside' the person, whose construed realities become either internalised or become decentred externally and potentially regenerative through self-discovery, unless the testing-out process is neglected.

Ethical constraints can be imposed by power-relations within groups. Habermas (1987) found that individual constructs can be erased by a focus upon powerful group relationships and social forces. Further, it would be an omission to ignore the influence to the person who is affected by assumptions that negative symptoms in mental health represent the absence of normal functioning, while positive symptoms denote the presence of abnormal functioning (Leach, 1991). A constructivistic dynamic, ranging from unconscious
construing to cultural constructions, poses an ethical dilemma in analysis. Therefore, analysis is at the level of paradigm research, in the investigation of self-discovery. That is, the constructions of hospital life, the community, of individual investigated people, and professional people, form a multiplicity of personal and group realities that comprise a constructivist paradigm.

The ethical dilemmas that are posed in this chapter derive from the literature research and experience during a pilot study. The pilot study in particular made clear that an imbalance in the staff and patient participation is significant. Two frameworks are devised on the basis of prior constructivist research in the fields of education and mental health care (Belenky et al., 1986; Kitwood, 1988, 1989, 1990). They are examined in the methods chapter which follows and introduced here to disclose the ethical concern that surrounds the effect of staff-patient and hospital-community relations in the early study.

For example, one lady in the study completed the video-recording assessment (Appendix II) without revealing her construing about the self-image on the monitor. She said all the 'things' that she might
have thought a staff member, the researcher, might like to hear, despite the procedure being introduced informally in group meetings and individualised later. It was only when I went to her ward the day after an assessment session to 'follow-up', that she said she did not want to go to the cinema on a planned outing: 'I really don't want to see myself.' Subsequently, she decided to participate in the research but not to be video-recorded on a number of occasions.
CHAPTER FIVE

METHODOLOGY

Choice of Research Approach

Constructivist investigation is made explicit through a cross-dimensional approach to inquiry. These dimensions have included a cross-disciplinary examination of literature, a reflexive personal account of the researcher's orientation to the field, a critique of constructivist philosophical thinking, and the assessment of associated ethical dilemmas. Personal and moral aspects of research science are of particular interest when the context of investigation is community mental health care. Therefore, methods of processing data should account for its ever-changing nature. Chapter Three in particular, but also Chapter One, contain discussions about the nature of personal knowledge. Moral aspects of the data are referred to in Chapter Four, and a case study is provided as Chapter Two.
In line with an approach that would explicate constructivist research, the method of conducting research is intended to be a heuristic process. Because 'heuristic' and 'hermeneutic' are words used in describing a constructivist approach, the researcher expects that the investigative process may be influenced and affected by change, or chaos, and his own judgements. Given the 'uncharted waters' of a study that is teeming with discrete realities of individual, social, and cultural constructs, a method chosen to keep track of the data is to record it through the lens of a video-camera. The instruments of data collection as they are used in action have that permanent record upon which to examine and re-examine the evidence.

Added to the conventional instruments for research, e.g. semi- and structured questionnaires, and researcher's fieldwork observations, video-recording is to be uninterrupted and unstructured during the year, in the house meetings, team meetings, and triad sessions, which involve the researcher, a house resident, and a staff member. These relatively unstructured incidents of data collection are the main focus as a resource for generating knowledge about the method of constructivist investigation.
Constructivism as it emerges from the early chapters represents an alternative methodology in the context of transition to community-based residential care. Inherent in the methodology is an affirmation of personal knowledge and experience that redresses limitations in conventional research in the field of mental health care. And it offers a testable alternative to the characteristics of hospital life, where self-discovery was submerged in the lifestyle of chronic institutionalisation.

There is tension between 'pure' or 'value-free' research and research that affirms values. The present study proceeds to examine a personal dimension of science, which may point to a bridge for the conventional subject-object research dichotomies.

It aims to examine the contribution of the investigated people, as applied to the relationship between self and the content of one's inquiry, and the relationships between the act of knowing and how knowledge is viewed. Therefore, the methodology aims to allow the unchartered expression of personal values
and beliefs, which underpin a constructivist approach to investigation and which make science possible in the first place.

This approach to research method is indebted to certain 'structural' aspects of the study, as well:

a) The collaborative nature of the employer-university venture to integrate the research in purposeful job-related outcomes, i.e. using the research to better understand educational needs in the transition to community care;

b) Matching the research to the employers needs, i.e. the research coincided with the development and opening of the supported housing project, when the first cohort of patients and staff moved from hospital to community-based care;

c) The ethical need to allow the cohort to be self-selective vis-a-vis their participation in the research, given the personal circumstances of their many years of hospitalisation.

Questions raised about categories, e.g. 'Is he reasonable or insane?', are usually based upon the
givens of clinical pathology, applied to people and, in turn, shape research design and give prior knowledge to current method. Referred to earlier in the thesis as scientific or Cartesian Anxiety, the approach to questions and categories is attempted in a constructivist paradigm that yields to the values and beliefs of participants. There is a question about methodology that yields and in this study it pertains to the relevance and use of knowledge, for practitioners, teachers, managers, service users, and researchers, who may wish to use a constructivist approach.

Given the researcher's orientation to the field of study and a constructivist approach to literature research, a relevant question evolves, in the transition period from hospital, about the use of self-inventiveness, self-discovery, consistent with livelihood in a community. Through the combination of scholarship as a traditional method of conducting literature research and a constructivist approach to the literary and main study research, it is intended that a constructivist, investigative ethic permeate the research process.
These points provide a constructivist 'signature' in the annals of research, where convention is to avoid personal referents in the name of scientific method, as a device to ensure a foreseeable outcome (Mair, 1988, 1990).

**Entry into the Field**

The research was proposed and conducted in the context of the researcher's job. The post involved the teaching and training of multi-professional staff in the transition from hospital to community-based care.

The job required identifying changes with short- and long-term educational strategies for designing and implementing curricula. Educational research had been the mechanism for identifying such changes in his post since 1983, when first employed as an in-service training officer.

Entry into the field of research was supported by the Continuing Care Unit in 1988. The question posed for educational research was 'What would be different about training given the difference between hospital and community-based care?'
Three educational products were anticipated during the four-year study. One, an in-service training for all grades of staff, from any background or profession, entering the new community service. This course, in three-, five- and eight-day formats and later in one- and two-day workshops, was introduced following the first year of literature research and prior to the opening of the first house in January 1989. Second, the English National Board for Nursing and Midwifery Course 811, for community psychiatric nurses, was to be updated by designing the ENB 812 Course, to replace it. Third, arising from the research a new Course, the ENB 993, with validation for multi-disciplinary training, would prepare qualified staff for Residential and Day Care in Mental Health Services. The second course was validated in 1989 and the third in 1990. The curricula are discussed further in the Fieldwork Relations section of this chapter.

Aside from the educational focus upon entry to the field of research, my identity as a mental health professional was mediated to some extent by being known as a person, as discussed in Chapter Two. By the nature of past practice with patients there is a known sensitivity to intrusion, for example, and known respect for patients as individuals of equal standing.
vis-a-vis ordinary values of self-respect or privacy.

The degree of personal knowing and trust in existing hospital relationships enabled my entry into research, and into the lives of people, to be less than that of a total stranger. Moreover, Llewelyn (1984) found that emotional respect is seen as particularly important by patients. As a relative stranger with a hospital-based network of friendships and working relationships, the effects upon acceptance, design of the study, and consistency of the data, may be less susceptible to being corrupted by the researcher than might be in the case of the purposeful stranger. On the other hand, one could argue that such a researcher might lure the participants into an agreement which, with a total stranger, they might be more able to make an outright refusal. However, a knowledge, understanding, and sensitivity to their experience would seem a more natural basis for objective communication with prospective participants than a relationship lacking those qualities. Indeed, participants in this study will be aware of a continuous option to opt in or out of video-recorded sessions, or to erase data. It is intended that this will be acknowledged at the data collection opportunities throughout the main study year, during
Data will be received when the residents and staff are ready. Residents and staff may be present or absent for various reasons and continue to opt in or out of participation in the study.

Negotiating Participation

The basis of equity in the study is organised upon a triangle of contracts, procedure, and design. It is intended that the study open itself to being accessible for participation by its approach to investigation. The contracts are well-grounded and flexible agreements. The procedure for data collection allows for variation in participation and demands the researcher's immersion in the study. The design is naturally-occurring; it coincides with the commissioning of the supported housing project and its first-year cohort.

Contracts

Staff were selected to work in the supported housing project by representatives of a multi-professional management team in continuing care, while patients were selected to live in the houses by hospital social workers and a psychologist. The researcher did not
participate in the selections. The first staff and patients were selected six months before the first house opened in January 1989, as outlined in the foregoing chapter. Non-hospital staff were also appointed.

Initial consent (Appendix I) to participate in research was sought after a six-month period of intermittent team-building and team-meeting sessions with the researcher. At this point, the one-year pilot study had been ongoing for six months. Once the orientation period was tried, and in that sense tested, the period prior to consent was three months for the second and third houses. That time was taken to ensure people knew each other and were used to voicing their opinions about their work and life in the houses was important to the researcher's assessment that they knew the consent was not binding.

All of the contracts for permission with people who live in the houses were made after the move from hospital was complete. The researcher's affinity with the project as a starter-member was discussed in Chapter Four.
Procedure

The data is to be collected by unstructured exit interviews, semi-structured interviews of staff and residents, structured questionnaires for residents, and during unstructured staff meetings, triad sessions, and house meetings. Triads are a voluntary coming together of a keyworker, a resident, and the researcher to explore current interests and issues in a way that may facilitate self-assessment, self-analysis, and self-discovery. Exit interviews, triads, house and team meetings contain this purpose in the research. The Fieldwork Relations section of the chapter will elaborate the personal methodology.

Data was documented by the uninterrupted video-recording of all the procedures, except the recording of field notes and observations on the individual index of contacts. The permanence, constancy, and fidelity of recorded data was in itself different data for re-examination. That is, it can be seen on the spot, in retrospect, for self-assessment, for instance, or later for review, and of course during transcription and data analysis.
The video-recording procedure (Appendix II), derived from Heilveil (1983) and Jenkins (1987a,b), provides a number of features that are consistent with the research focus upon self-discovery:

a) It yields a clear, concrete take-away picture of the world, or referent to meaning, as seen and experienced through the physical senses and theories of the participants, including the researcher;

b) Video-recording can be played-back on the spot, or be reviewed later, and is available for self-assessment by participants, e.g.:

   (i) to erase moments that are deemed objectionable;

   (ii) to confirm what data is recorded;

   (iii) to self-assess for then-and-now comparison in evaluating goals;

   (iv) or to review consent.

c) It releases the researcher from the paper-and-pencil exercise of collecting data on the spot and the distortion of observation through a percipient's bias or loss of memory.
The ethical and practical efficacy of the video recording was questionable, with people leaving the institution after a number of years, and this is the principal reason a one-year pilot study was envisaged and conducted. Secondly, relationship-building by and with the researcher would take time. Piloting of the video-recording procedure (Appendix II) began in June 1988.

While the exit interviews and the video-recorded participation of the researcher are reported to be unstructured there are criteria that emerged from both the literature research and from his role as an educationalist in the collaborative health authority and university arrangement supporting the study. The nature and background to the criteria are described in the Fieldwork Relations section of this chapter.

The spectrum of the researcher's construing will include the vantage points of participant, observer, and interviewer. The advantage of different perspectives is that they may enable the researcher to 'move' with the other participants in their construing and reconstruing, hypothesizing, testing, and reconstruing. While the research, for the purposes of the thesis, aims to generate guidelines for the use of
a constructivist approach to living and working in the field, the participants should also gain direct here-and-now, in depth experience of the personal constructivist process.

Design

At proposal stage to the university and to the health authority, an approach to personal research specified the need for prolonged engagement, persistent observation, and triangulation. It was also characterised by having a focus, rather than a specific problem or question. A commitment to cross-disciplinary investigation to find a constructivist approach places the study at a level of paradigm research, in contrast to the study of a single or a particular concept. The early chapters of the thesis explore the practical and theoretical frameworks which further focus the perplexing world of life, work, and research, in community care, to the people who are involved.

Samples, groups of people to be in the study, are planned to include individuals who live and work in the first staff-supported houses of the mental health
service. There are three waves of participants, as three houses opened during the first year of transition from hospital to the community.

Data from the samples would emerge in order, i.e. the first house opened in January 1989, the next two in June, 1989. Piloting of the video-recording, and the other instruments, was divided into preliminary piloting six months before the first house opened, and the concluding six-month pilot study between January and June, 1989. The main study is comprised of data collected between June, 1989 and June, 1990. Piloting before and after discharge from hospital provided a testing-ground for the consent protocol and the video-recording procedures.

In contrast to the conventional enquiry, where a researcher usually approaches 'knowing what is not known', the research adopts the naturalist position described by Lincoln and Guba (1985, p. 235) of 'not knowing what is not known.' The effect upon design of this approach is that the research is open to continuous refinement, and to unexpected change in the course of study. That is, the study enters phases in
order to find out what is salient, to search further, and to check findings through the trustworthiness of its procedures.

The question of design restraint is significant in this study, insofar as it emerged following the health authority's requirement for proposal submission in the normative format of conventional research. In what began as what may be best described as a conceptual blizzard with the Research Endowment Committee, ended with the proposal being supported for consideration by the Ethics Committee. The proposal period spanned several months during 1987 and was instrumental in testing the principle of the approach and design of the research in an arena of scientific skepticism.

The influential double-helix of research and practice (Chapter Two) is an example of a multiple-constructed reality, i.e. of the experimenting self of the mental patient and his carer, which is the origin for the researcher of the research design. The notion that practice is based upon research, the latter informing the former, is reversed in the present study, to the extent that it is a methodological study. The educational adviser conducts research, using an
approach that subjects the researcher to a level of practice of questing himself. Thus, the researcher as a participant is also focussed upon a method of self-discovery. The purpose of a design, as Lincoln and Guba (1985) put it, is to enable the researcher to enter into:

a kind of dialectic process that plays off the thetical and antithetical propositions that form the problem into some kind of synthesis.

(Lincoln and Guba, p. 227)

Fieldwork Relations

What happens in the field, during research, is of particular significance in mental health care, owing to the multiplicity of variable influences that cannot be controlled. The individual, social, and community life of participants in the study could not be dissected, and interesting parts of body, mind, or social fabric 'frozen' for study in an investigation of a constructivist approach to self-discovery. The content of the research and the sources of data reflect the context of the transition to community-based care and the context of the investigative approach.
Content

The main study began in June 1989, with house meetings, team meetings, and triad sessions, and the first exit interview was in August. There were two aspects of methodological structure in this work. One derives from the literature research and the other, subsequently, from curriculum development of three staff development courses. What the teacher is trying to do as an educational practitioner, which will be discussed now, is applied to the research and made manifest in the 'unstructured' house and team meetings, and during exit interviews and triad sessions. Thus, an investigation of a constructivist approach to self-discovery includes the personal methodology of the researcher, as the result of the educational interests of this study.

Each of the three courses reflects an advance in the research, as, for example, the literature review is progressed. Figure 1 depicts the context of the investigation, in relation to the developing thesis, the experience of the research participants in the supporting housing project, and the three courses. Advances in the progression of the curricular by-products of the research denote a developing constructivist approach to investigative technique in the act of researching.
Figure 1. The context of investigation in relation to the developing thesis.

The study's action research effects are represented here, as the empirical basis of inquiry is reconciled in the educational practice of three curriculum development groups and subsequent courses of training.

Knowledge and experience of the main study participants in three residential settings.

A synthesis of prior knowledge that constitutes a theoretical underpinning for an investigation of a constructivist approach to self-discovery.

Personal constructs of the researcher, as an aspect of fieldwork and field relations.
Transition (in-service) Training was influenced by the literary findings that focus upon valued accomplishments—the things that a service needs to accomplish in order to be a service of quality.

Such a service provides a five-dimensional framework of quality based upon enabling people who use it (i) to experience personal growth, (ii) to develop relationships, (iii) to achieve a presence in the local community, (iv) to develop skills, and (v) to achieve dignity and self-respect (Wolfensberger and Thomas, 1983; O'Brien and Lyle, 1987).

Research and practice from this sociological approach to training has its focus upon peoples' strengths and gifts rather than concentrating on their deficits.

Two months of the early literature review were spent in North America, collecting data from 117 researchers, educators, administrators, project workers, and mental health service users.
During the visit, the educational experience of participatory research (e.g. Freire, 1973, 1985; Rose and Black, 1985; Shor and Freire, 1987) was examined in detail at the University of Massachusetts Graduate School of Education.

The significance of this work in relation to the transition from hospital is described in early chapters of the thesis and it is reflected in the academic version of transition training, the ENB 812, where the student experience includes, for example, weekly statement papers and reaction papers, as educational method for generating and using personal knowledge. People who use educational services would be treated as equal collaborators in the search for knowledge.

The early chapters of the thesis provide a theoretical linking between these two educational approaches and constructivist theory. These linkages form a constructivist approach that contains, by virtue of its theoretical connections, an investigative model
that matches, or replicates, good practice in community mental health care. The accomplishments approach of valuing devalued people is compatible, with the educational participatory research method of developing personal skills for the empowerment of disempowered people. The Philosophy Chapter (Chapter Three) in particular is used to integrate and study this work in a constructivist context. Before it was written, personal construct psychology (for example, Kelly, 1955; Maher, 1979; Bannister and Fransella, 1986) was the principal link to the accomplishment and empowerment 'tracks' in a search for a constructivist methodology suited to an investigation of self-discovery in the supported housing project.

These developing findings in the literature research will find their practical application in the main study, as I struggle to methodologically represent the linkages with a constructivist philosophy to the accomplishment, the empowerment, and the personal construct aspects of investigative method.
The literature in question extends to Chapters Three, Four, and Five, insofar as examinations of philosophy, ethics, and methodology are linked in a cross-disciplinary review. The centrality of themes and issues are illustrated by and located in the three curricula by-products of the research (Nightingale and Guy's College of Nursing, 1989, 1990):

a) The principal design requirement for Transition Training was that it be service-matching, i.e. that the curriculum provide a learning experience that would match the requirements of support work in a community mental health service (Wolfensberger, 1980). Central to this was this accomplishment theme.

A valid community service would provide a 'framework of accomplishment' for people it serves (O'Brien and Lyle, 1987). Accomplishment is illustrated in Figure 2, by listing five dimensions of accomplishment to focus effort in community mental health care. The effort is an investment in the potential of people and validates their strengths.
<table>
<thead>
<tr>
<th>Community Challenge</th>
<th>Valued Experiences</th>
<th>Common Experiences</th>
<th>Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include all people.</td>
<td>Sharing ordinary places and activities.</td>
<td>Being separated by location, activities, schedule.</td>
<td>Community presence.</td>
</tr>
<tr>
<td>Protect integrity by creatively resolving conflicts</td>
<td>Making choices.</td>
<td>Limited voice, few options, no exit.</td>
<td>Protecting rights and promoting choice.</td>
</tr>
<tr>
<td>Develop all available resources wisely.</td>
<td>Developing abilities and sharing personal gifts.</td>
<td>Low level of contribution; unrealistically low expectations; deteriorating ability; physical hurt.</td>
<td>Recognizing interests and gifts; improving competence.</td>
</tr>
<tr>
<td>Offer valued roles to everyone by confronting limiting beliefs and their historical consequences.</td>
<td>Being respected and having a valued social role.</td>
<td>Negative reputation; prejudiced, inappropriate, limited responses from other people; negative self-fulfilling prophecies.</td>
<td>Promoting valued roles.</td>
</tr>
<tr>
<td>Promote interdependence among people.</td>
<td>Growing in relationships.</td>
<td>Few and restricted relationships; few memberships; isolation and loneliness; loss of connections; low personal power.</td>
<td>Community participation.</td>
</tr>
</tbody>
</table>
b) In contrast the qualifying course for community psychiatric nursing, was an academic training, as indicated by the validation process of the English National Board for Nursing and Midwifery (ENB). The ENB 812 further demonstrates the centralizing process of the thesis, by incorporating prior personal knowledge and experience with participatory research (Polanyi, 1958; Horton, 1983; Hall, 1984; Freire, 1985; Shor and Freire, 1987; Habermas, 1971, 1987; McKnight, 1987). In searching for a constructivist approach, advances in teaching and curriculum design were compatible and integral to an academic approach to community nursing (Stenhouse, 1975; Mezirow, 1981; Skilbeck, 1984; Knowles, 1984; Jarvis, 1985, 1987). Participatory training recognizes the value of popular knowledge and encourages people to participate in their own learning. Generating personal knowledge through statement and reaction papers is evidence of theory testing.

c) The ENB 993 course in residential care is a testing-ground upon the developing research. This development in the doctoral study provides a
preparatory mechanism for a constructivist approach to investigation. A progression in the investigation of a constructivist, or values approach, to learning, to self-discovery, has an exponential effect in all three courses. The 993 is a synthesis of Transition Training and the 812, and it is integrated with person construing (Maher, 1979; Thomas and Harri-Augstein, 1985) of the student and their client. Validated for multi-professional participation, the course involves students' personal clients in their training, in the context of their employment. The exponential effect is a collaborative inquiry in learning and health care practice by service providers and service users in the community context where they work and live.

The ENB 993 Course (Nightingale and Guy's College of Nursing, 1990) is designed to integrate educational methods of the accomplishment and empowerment trainings with the benefit of being tried and tested and nurtured by the research running in tandem in community-based care. An attempt to move away from institutionalised education was examined in Chapter Two, during a discussion of Hooper's (1990) work. Kelly (1955) had also argued for a shift in the

*See ADDENDUM A Reference to the Replication of Research
approach to learning, referring to the traditional education system as a 'hardening of the categories' rather than as an elaborating of a network of meanings (Bannister and Fransella, 1971, p. 88).

The effect of the progressing research upon the investigator is one of progressing constructivist method, in developing a method of being with people as data is collected. By February, 1989, still in the pilot study, the early work on the ENB 993 contained step-by-step criteria of what the teacher and collaborative researcher would do, citing Kemmis and McTaggart (1982), amongst the Australian educators integrating personal construct theory with participatory research (Freire, 1973):

a) Sympathetic understanding of the personal meanings that clients or staff have of themselves and their situations;

b) De-code their perceptions with self-described accounts of their world of experience and self-discovering; recognise themes generated by their experience and personal knowledge;
c) Further elaborate and identify themes in their descriptive data; critically analyse and present their themes in an objective context;

d) Your reality is made absolutely clear. Your critical analysis of their subjective themes is collectively, or jointly, analysed in the context of the original opinions (b) and problems for investigation are defined; the action they propose to take is recorded; strategic contemplation of action acknowledges their capacity to move from being the user of others' reality to being an active participant;

e) As a result of (b) and (c) clients or staff evaluate whether they have learned anything divergent from their previous construing of everyday experience; they elaborate and analyse consequences of their action;

f) They choose a stance for action or non-action—a decision not to act designates a person as a continuing strategist, but the die is cast for observation of an educational move from personal opinions to demonstrating a critical distance from their previous personal knowledge;
g) Informed participation and critical reflection occurs;

h) Personal and objective dimensions of the educational exercise are evaluated, observing accomplishments and reflecting upon the experience of client, or staff, action.

By the time the main study started, the curriculum corollary to the collaborative University-Health Authority study had progressed the researcher through the accomplishment, empowerment, and person construct positions to a broad constructivist understanding for an approach to the unstructured video-recording of the house meetings, team meetings, triads, and exit interviews in the main study. The method of being with people that is just outlined assumes that it is valuing, empowering and generates new knowledge. It assumes that helping a person involves searching for knowledge, not transmitting it from someone who is in possession to someone who need to receive the 'held' knowledge of the transmitter.

The researcher's educational role would undergo the natural changes of other staff roles as the transition to community-based care occurred. That is, given the absence of an 'institution' in community-based care,
there is a need to evaluate the contribution to self-discovery in an environment where self-sufficiency and self-attainment are more assumed than in hospital. To this extent the researcher inherits a natural place as a 'member' with the other new experimenters to community living and working, of what is happening when the houses open. The difference in his role before the houses opened was the absence of an investigative design to substantiate the evaluation, the finding-out, in a new and complex situation about the nature of living and learning.

Hunt (1989) argues that:

insider roles and consequent muting of the subject-object dichotomy threatens empirical objectivity. It is a threat with a corresponding gain. Without formal acknowledgement of the significance of intersubjectivity to the research process itself empirical objectivity is only attainable at the expense of the object.

Hunt (1989, p. 20)

Therefore, the argument would be that lack of knowledge in a field can relate to material that is inaccessible, as the result of a methodological 'miss-take'. The field content that the present
research aimed to seek-out was the character of self-discovery and its relation to educational enquiry. The heavily-researched hospital environment (Chapter Two) seemed to constrain and/or disbelieve self-discovery. Now the conditions had changed, what was the nature of it?

Data Sources

Data will be collected individually from the 36 people living and working in the three houses, and it will be collected in groups, as well. There are six contexts for data sources, across the field of research:

a) Staff arrange meetings once a week with the people who live in the houses;

b) Staff themselves meet once a week;

c) Once a month, a member of staff and one person who lives in the house intend to meet with the researcher;

d) On random occasions, the researcher will meet with individuals who live in the houses;
e) The personal experience of the researcher as a participant in the study is a source of data and is reflected in fieldwork observations;

f) Staff resigning from the service will be asked to provide individual exit interviews.

The analysis of literature provides a further data source. Scholarship as a traditional method of literature research provides a synthesis with respect to the moral and personal values of scientific method and its relation to and respect for knowledge and the rules of evidence in what is considered a human, or personal, science. The main study involves the collection of new data and its application, or testing, with the theoretical linkages that define a constructivist approach.

Analysis and Presentation

The difficulty of being expected to know in advance is a feature of this methodology, as it is indicated in the Design section of this chapter, in contrast to the anticipated deductive analysis expected in conventional research.
The difficulty that I anticipate is being expected to know by research participants, as the result of experiencing this with health authority supporters of the study. Another difficult aspect of the developing methodology has been the researcher's personal discipline and technique as a constructivist, as outlined in the Content section of Fieldwork Relations.

However, as an educator in a psychotherapeutic setting, to accommodate a personal model of the method within the data collector appears compatible with the research purpose in a community mental health care context. The model 'within' is intended to replicate a model 'without' that is compatible with an open-ended, inductive analysis, where issues and themes arise as the enquiry proceeds. Lincoln and Guba (1985) encourage the development of the best means to make sense of the data in ways that facilitate the inquiry and maximise understanding.

Ethical issues that arise in Chapter Four are instrumental in the decision that analysis should
expand the opportunity for the residents' data to impinge on any explanation of the study. The rationale also derives from anticipation that resident and staff views may be as discordant or contradictory as they may be unbalanced in terms of their size.

A dialectical characteristic of constructivism is a third factor in developing analytical method. Thick description and dependability in the trustworthiness of the researcher's field relationships are criteria identified in the confirmation of research as being valid in a constructivist sense (Lincoln and Guba, 1985, p. 328). Evidence in narrative format is significant, compared to a statistical result based on a classification system for data. Analytical criteria combine with prolonged engagement, persistent observation, and triangulation of collection methods to assure credibility.

Three thesis chapters will be devoted to data presentation and three to analysis, although a final chapter is entitled Data Reconstruction and Synthesis.
A Bipolar Framework with Six Domains

Figure 3 illustrates the first of the analytical frameworks. This is one of two infrastructures that is used to amplify data, in recognition that it may represent an amorphous knowledge-world of multiple realities, which may invariably have the effect of decentreing from the self. A constructivist analysis exposes the evidence to these effects. The inter-linking constructs of the various players directs that an investigation give credence to tacit knowledge.

The framework is an interface with multiple realities that allows the evidence of participants to elaborate outwards in a fuller admission, than a statistic, of what the data means.

A bipolar framework takes account of the personal process of construing (Thomas and Harri-Augstein, 1985) and the perpetual changes in construing and subsequent conceptual restructuring (Watts, 1988).

Abstract dichotomous thinking is often represented in a repertory grid technique involving data collection and analysis of homogenous categories (Morrison, 1990). Heyman, Shaw, and Harding (1983) have
Figure 3. A bipolar frame of reference for data analysis, in which the constructs of the research are processed. The idea of the frame is derived from constructivist research by Belenky, Clinchy, Goldberger, and Tarule (1986). Guideline questions are added to indicate the researcher's thinking.

1. Process Oriented...............Goal Oriented
   Means                           Ends
   What are the anticipations of knowing?

2. Discovery.......................Didacticism
   Constructed knowledge           Received knowledge
   Is there a view about knowledge and becoming a 'knower'?

3. Intuitive.......................Analytical
   Gut feeling/subjective          Logical, objective
   What methods are used, or are valued, for analysis?

4. Support..........................Challenge
   What are the best conditions for self-discovery?
   Who and what are experienced as supportive or challenging?

5. Personal.........................Impersonal
   What is the relation between self and one's enquiry?

6. Self-Concern.....................Responsibility and Caring for Others
   Is this dichotomy an issue in self-discovery?
questioned its relevance to real mental processes. However, the bipolar principal is used in a narrative way by psychologists and an educationalist (Belenky, Clinchy, and Goldberger, 1986; Kitwood, 1990), whose constructivist approach to analysis is used in this investigation.

In the original research, the six domains of the bipolar frame of reference were referred to as educational dialectics (Belenky et al., 1986). In addition to providing a broad constructivist paradigm, its affinity with the present research also lies in the will and questing for knowledge that is hypothesized in its framework and in this study as self-discovery. The domains provide a template for construals and address constructivist issues.

The first domain, Process Oriented to Goal Oriented, provides a framework for a question about self-discovery, e.g. 'What are the anticipations of knowing?' Other questions are indicated for individual domains in Figure 3. It is intended that data is selected for the framework, using the person-as-method technique of the researcher's judgement, as a constructivist approach to analysis that is consistent with a study of method.
A Moral Grid

The second analytical framework, Figure 4, also enlarges the experiential frame, in anticipation of conflicting realities that may exist within individuals and within groups. The Moral Grid is intended to amplify the data, in a constructivist approach to study personal and intersubjective patterns, rather than to make moral judgements. A narrative presentation of data will be used, to best represent personal observations of reality. Healey (1990) argues that neither theory or experiment are reliable in mental health care because:

It is only likely to be when the effort to describe is made in collaboration with others that what is happening can be deconstructed.

(Healy, 1990, p. 217)

This collaborative-interactive framework for analysis follows the style of early investigation in the thesis, examining the 'messy' end of the scale (Schon, 1987) where little is known about the goals and values of mental health care as a human science.

The Moral Grid is based upon Kitwood's (1990) hypothesis that the giving of free attention is a moral skill of which the world is deficient.
Figure 4. A moral grid, in which constructs are for analysis. The moral grid is based on Kitwood's (1990) research in the morality of psychotherapeutic practice. The axes of the grid represent degrees of high to low expressivity (E) and high to low structured domination (SR), as described below.

<table>
<thead>
<tr>
<th>E</th>
<th>HIGH</th>
<th>LOW</th>
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<tr>
<td>1</td>
<td>Situations where power is unrestrained in personal exploitation. There is little, if any, moral space allowed. There is an absence of free attention to the subjectivity of another person(s). There is a lack of care for the capacity of another person to make discoveries. A person's experience is disregarded or re-framed in an unrecognised gloss on the experience of those in power.</td>
<td>There is an ideal of equality and mutual respect; but the scope of experience to which these ideas apply is far greater than in Quadrant 3. Individuals are treated as sentient beings, with all the complexities and disjunctures which that implies. There is a reliance on lived experience and already existing praxes, albeit confined to miniture insulated contexts.</td>
</tr>
<tr>
<td>2</td>
<td>The imposition of control. Considerable restraint on the part both of those who do and those who do not have power. Confrontation is generally avoided. Limited moral space is allowed because the vested interests and distortions of subjectivity brought about by structured domination tend to prevent real meeting.</td>
<td>Structured domination and expressivity are low. As in Quadrant 2 individuals are expected to be relatively inhibited and restrained. They state their interests and desires, perhaps, but alienation is observed, in contrast to integration. People wish to treat one another as equals.</td>
</tr>
</tbody>
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Moral space (Figure 5) is the result of free attention on the part of the one person effecting free attention on the part of the other. Each quadrant in Figure 4 contains an operational definition. Quadrants 1 and 4 are characterised by many tensions and non-comprehensions. These could erupt into minor acts of violence. Quadrant 2 reflects a set of socially-situated rights and duties. Quadrant 3 is occupied by liberal theories whose theorists are undergoing change and rationalisation. Morality is moulded by the category of 'ought', or occasionally that of 'rights'; but the scope is different from that of Quadrant 2, because persons are accorded value not because of their social position but because of being human. Quadrant 4 points to a present opportunity: the way is open for expansion of intersubjectivity as constructs are tested-out. There is an enlargement of moral space emerging from a fuller range of personal constructs being elaborated outwards. A deeper type of mutual respect is observed.

The judgement for placement upon the grid is, once again, the responsibility of the immersed researcher who, for the purpose of the thesis, is investigating a constructivist approach.
Figure 5. Moral space in a field of experience. In moral space, each person is able to take the other's subjectivity seriously, with feeling and understanding, while also being very much in contact with his or her own. This is portrayed in the field of experience below. The large circle represents the totality of what a person is undergoing, whether or not this is known in consciousness or grasped in symbols. The small circle represents what a person knows consciously, whether or not this corresponds to his or her lived experience. It is the area where the two circles intersect that represents a person's authentic life; and moral space is created when this area, for one individual, interacts with that for one or more others. The moral space so created provides a kind of closeness, but without loss of individuality. Of all types of 'spaces', e.g. work, play, sexuality, Kitwood (1990) argues that the moral one is the most formative, the most fundamental for our existence as persons.
A constructivist analysis is intended to be a heuristic device. It generates hypotheses from the data about how to interpret the data. Reiterative patterns of data are studied, to yield emergent themes, or issues, about what it is that characterises the investigative approach to self-discovery.

The research is questioning a method of being with people. The study is a concomitant examination of investigative method, because the way in which the research is conducted is an evaluation, or test, of a method of inquiry that is part and parcel of a method of being with people that constitutes learning, development and growth.

After video-recording the data will be transcribed verbatim by the researcher. Transcripts will be read, the text segmented, reassembled and the data examined again many times, paying particular attention to the lived experience of the people in the study, without 'losing' the original construing on video-tape. A constructivist approach to the self in a social
context will be a process of data reduction that involves selecting, focusing, simplifying, abstracting, and transforming raw information (Berg and Smith, 1988, p. 362). Processing data on the bipolar frame and on the moral grid is intended to inform the study of ways in which residents and staff construe their experience of themselves as developing beings and experience their learning environments.

*See ADDENDUM  A Critique on Data Processing
CHAPTER SIX

DATA FROM WENTWORTH STREET

Data is presented from two team meetings, two house meetings, 12 semi-structured interviews, five structured questionnaires from the residents, and four exit interviews from departing staff. Exemplars from the narrative are processed on the bipolar frame of reference and on the moral grid, referred to in the previous chapter.

A system of notation will identify speakers, e.g. bracketed [] R = resident, S = staff, BL = researcher, with numbers 1-36 signifying staff and resident participants within the brackets, e.g. [R3]. Pseudonyms are used in the text, where names occur naturally in the narrative. Brief collective responses by more than one person will be segmented by a | mark, to denote where one person's construing stops and another starts. Longer collective evidence will be 'boxed' by a continuous line over and/or under the data.
The data as a body of evidence is viewed as a collection of 'snapshots' from individual and group processes of construing and reconstruing, as individual thinking is tried and tested in the field of personal, social, and cultural experience. Data analysis in the next chapter will initiate a process of reconstruction (Lincoln and Guba, 1985; Belenky et al., 1986; Habermas, 1987; Healy, 1990). Presentation and analysis of data will be exponential in the following chapters, as it accrues from the other houses.

From the personal profile sections of their semi-structured interviews and structured questionnaires, there is a notable difference amongst statistics that characterise the patient and staff as discrete groups of people. At Wentworth, the average age is 63 for the three men and two women who lived there, compared to the 30 years average of the seven staff. The past tense is poignant, because two patients were moved from the house and four of the staff resigned. These events will be evident as the data is further elaborated.

The average of total in-patient time for the five people who lived at the house was 14 years. Two people
had lived in hospital less than 10 years and three people were in-patients for 15-21 years. By comparison, four of the staff had experience of psychiatric hospital, by virtue of nurse training, with up to ten years of practice. The remaining three staff worked less than five years in residential care settings, assisting people who were elderly or mentally ill.

Two people moved into the house as an unmarried couple. One person was a single lady who had never married while the others were divorced or widowed men.

**Staff Perspective**

'Answers' to the seven 'personal profile' questions, which formed part of the semi-structured interviews, were written-down on paper by the staff and patients as well as being video-recorded. Therefore extra comments were not missed in the event of any difference between their remarks and their written comment. Three of the seven staff, all trained nurses, referred to their own personal lives and
managing their life at home in particular, as being of most practical importance to their work at Wentworth Street.

'Awareness' and 'ability' occurred in more than half the responses to the question 'What's most important to you in doing the job you have to do here in the house?' Some phrases used were:

Being aware of where to start and when to let go. | Awareness of the needs of each resident. | Awareness, that is knowing, what's to be done and how to go about it.

Other responses refer to the:

[S6] Ability to empower people who use services rather than using your own power to make people do things that you think are right because they are right for you.

[S10] Ability to get down to the practical face-to-face kind of helping that is not domineering but enabling for residents.'

Resident Perspective

Three of the patients recorded qualifications, a secretary, a teacher, and an architect, while the two others referred to their childhood schools. Life experience found valuable included 'having to fend myself, 'living with other people and learning to adjust, 'helping in the kitchen and laying tables at the hospital.'
When asked 'What was the address where you lived before you moved into this house?', three people in this house, and seven of the twelve residents in the three houses, wrote an address where they lived before hospital, even though they were at hospital before moving to this house. This was a significant omission in light of their confirmation that they had come direct from hospital to this house but did not change their response to the question. Their interpretation of the hospital as not being a place where they lived gives qualitative difference in the meaning of the word living, such that it would not be associated with an address in the community where they had lived.

Referring to what was most important in living at the house, people referred to 'My freedom', 'having some privacy', 'learning to adjust to other people I live with', 'to be able to come and go', and:

[R1] I can't tell you because it's more or less retired from the jobs. It's alright. I find it alright. Once you have settled into a place similar to this, you get away from these mental fellas. It's okay. You begin to see life. To see life.
Semi-Structured Questionnaire (Appendix III)

Staff Perspective

There are three staff responses, as the result of the four Wentworth resignations before the end of the first year. However, those four staff gave unstructured exit interviews, which in the process, informed the development of the semi-structured questions that were used later in the study.

The three respondents referred to what two of them called 'practical matters', e.g. helping with the cleaning, cooking, shopping, laundry, bathing, and the team leader, on return from maternity leave, was not satisfied that these matters were being accomplished:

[S8] I am trying to set a routine. In my own house we have a routine. When I am not there, my husband, or whoever is at home, knows that if I was there this is how we do things. What it's like being in this house is that if somebody goes off sick and we get someone else from another house to come in here, they don't know where to start because there is nothing written to say that this is the procedure, or this is what we do on Mondays, when you come, these are the things that happen on Monday. You don't want to fall back on institutionalising routines, but in life, even in banks, this is the time when we count the money. So if none of my staff was there, I don't have to come back and find that what should have been done hasn't been done because of another staff. Also, making sure that all staff know what should be going on
because when things have not been done in the house it is because people say, 'Oh, I thought so and so.' Those people have never really been told or been aware of what is going on. They were just doing what they thought should be happening. I am making in-house policies.

Another question refers to groundrules for working in the house. Two of the support workers said that 'the patient is number one', 'The residents are ultimate priority; this is not my home -- everyone has different values and those values are important.'

Another ground rule was to do with helping:

[S9] When I come in, I look around and see what is to be done and I have the residents do it with me. If the kitchen floor needs mopping, I say, 'Well, you will have to share to do this with me' and eventually they will do it themselves.

The team leader said:

[S8] The ground rules are to be observant, see what needs to be done and do it or help the residents do it. Residents are going three or four days in the same clothes. It is dirty. Obviously we are not supposed to impose our views, because we might have such high standards and others may not, but we expect to meet half way. What I expect from staff is that half way. I say to the staff 'Please remind the residents to change their clothes.' It has been said to me 'Well, they like that dress.' They like that dress when it is not dirty!

The most difficult part of the job for the support workers was 'low morale; basically feeling undervalued' and the 25-hour shift, as it was seen, created by the 'sleep-over' in the house, which
occurred once a week for most staff, and 'that is too many. If someone is ill and they don't come in then you are stuck.' The team leader's response, as before, was more elaborate:

[S8] Getting people to understand why it is necessary that we change and start working in a direction which is more educating the residents, rather than do for them. Things have to be done and the feeling is that it is quicker and easier to do them and leave the residents out. So we have come from a situation where nothing was being done to the extreme of everything is being done by the staff, but again the residents are still suffering. Trying to help the staff strike the balance is most difficult.

The penultimate question is in two parts, dealing with the educational researcher's query about what might have been known about beforehand that could have better prepared staff for the in-house work. All three staff said, on reflection they did not know what was expected, e.g.:

[S8] Although I live in a community myself, I didn't know what was right and what was wrong. There was normalisation in the extreme and being very restrictive or protective to the residents at the other end. I just found myself thrown in the deep end and had to start thinking.

One of the two support workers said there 'should have been more authority and direction' before starting work in the house:

[S7] I mean, because of me as a person, my personality has a specific way of working. I've
got a different, you know, I've got a specific angle on working with people, you know, the way I do it. If we'd have put that together, I would feel, am I an appropriate person for this or am I not? And I would have either selected or deselected myself.

About the question of what could have been known about beforehand, another support worker referred to one of the residents who was returned to the hospital:

[S9] I personally think that some of the residents who were allocated to us were sold to us. We were told they were capable of doing so many things. You remember when we started having trouble with him. We went to the manager and the psychologist and said perhaps he was placed in the wrong house. We were told 'No, he was not.' They made a mistake! We were stuck with this man. We realised he was going to be a problem and he was until he left. We were proved right!

The staff also said they required skills in assessing residents and planning their care. One of the support workers complained that the 'wrong people' were being selected to work in the house because they were not trained or did not have experience of working in a caring profession.

In responding to the final question, about what would be changed to improve the situation, the staff referred to further issues than indicated in their responses about difficulties in the job. These new issues were a lack of training 'on medication', a lack
of supervision, being able to 'work with people who do not have quarrels' and:

[S7] feeling underused, I mean on the less practical things that demand personality. Because that's how I feel about the job, about you know I don't have degrees or anything so I rely on my personality.

Resident Perspective

By comparison, the extent of evidence from patients is less than that of staff. However, a structured interview was developed for residents only, to provide a further opportunity for the study to 'hear' their evidence. Further, the bipolar frame of reference and the moral grid are a recognition of anticipated differences in the content of data given by staff and patients.

There are five succinct descriptions of what living in the house is like:

[R2] Just stroll along; I'm not really happy, not really unhappy; just stroll along.

[R3] It's much better than living in hospital; it's a better environment for one thing--there's not a mass of people around for one thing; more freedom.

[R4] The hospital was terrible; you've got all these patients all of the time shouting and
carrying on—here there's privacy, not just a space in a dormitory; I have plenty of freedom; it's pleasant.

[R5] I cater for myself.

[R1] There's two of them that the staff have noticed—mark my words, those two make it uncomfortable. If they leave we would get on very well.

Regarding groundrules for living in the house:

I do my own washing; I don't know what the rules are—I'm careful about what I get up to. Keep things clean and neat; nothing really. I didn't know there were any. You do what you're told and you ask for anything else. To help the staff if I can and to help the patients if I can.

Asked what is different now, compared to hospital living:

[R2] No nurses to worry you normally; it is better for us living here; it's quite a pleasant place but I don't get on with people—I'm struck dumb, you see, really, and other people speak for me, really, and I don't say anything.

[R3] There's freedom. You've got your own home; I eat better.

[R4] I don't have people bossing me about, interfering.

[R5] Hospital was a miserable place.

[R1] The hospital is a place where you go to have to be moved when you are ill and they help you to get on in life; here you get up in the morning, wash yourself—you can't be off sick.
Responding to the question of what is most difficult:

[R2] I don't know, you see; I don't have conversations—making conversations; I can't make conversations.

[R3] You have to look after yourself more in the house, whereas in the hospital you get the support of nurses for everything you want and need.

[R4] I don't find much difficulty.

[R1] You've still got to take your tablets; if you can do that, fine, you get on with it yourself—there's nothing hard about it and it helps you a lot.

The penultimate question referred to what might have been known about before the move from hospital that might have been helpful after the move:

[R2] Yes, the question's clear enough, I just can't, no, I just can't say, I don't know.

[R1] Before I had a kind of blank period. When I come to this house I was left alone by most of the staff really and I got used to get on with meself. Do odd jobs. If I was wrong, then naturally enough I was wrong. I think me illness made me blank. I'm here doing little bits and pieces of what I used to know. Once upon a time I used to know.

[R3] Well it's mainly shopping and cooking, isn't it? I can't think of anything else. I had some self-care money in hospital, and I did a bit of that. It was not as much as I get now.

[R4] Possibly. Can't think of anything. Couldn't say. I would have thought I might have known, but obviously I don't.

[R5] To be able to cook. Being able to get on with other people.
Finally, what would you change to improve the situation?

[R2] No ideas really; I hate two people who live here; apart from that I think I get on alright living in this place alone.

[R1] Anything I want I say at the house meetings and I hope we can get those two out!

[R3] Not so much cooking and washing up.

[R4] I wish there wasn't so much hassle; I think they're going to force John and me back to the hospital--nothing else is being arranged.

[R5] I want to live with Marie in a flat.

The Structured Questionnaire (Appendix IV)

The 105-item questionnaire was designed to provide an opportunity to redress the observable imbalance throughout the year in staff and resident data, to expand the resident perspective, and to provide a broader base from which to examine the connections between what people say about their work and what they do. Processing data through the bipolar frame of reference and the moral grid may amplify this point. The structured questionnaire, by its very nature, is the only data not compatible with the 'open' coding structure for the frames of reference. The structured questionnaire is, in the main, a series of boxes that require a 'yes' or 'no' tick.
Four of the five residents were less than very satisfied with the help they received in a crisis, and two being somewhat dissatisfied. Similarly, to the question about how satisfied they were with where they were living, four residents were 'somewhat satisfied', rather than 'very satisfied', and one person 'somewhat dissatisfied', rather than 'very dissatisfied'. The open-ended questions which followed yielded self-descriptions about what they liked best and least:

Bedroom. | Able to come and go as I please. |
My freedom. | I can have a meal when I like. |
Free to see things run smoothly--having a hand in what we do.

House is too small. | Housework. | Too many people in the house. |
Meetings. | Those two people make the house untidy and dangerous with their smoking.

In their individual ratings on a 1-10 scale of opposite feelings during the past month, three out of five were not concerned about their health, three out of five were relaxed, two out of five were energetic and four out of five cheerful. However, in their ratings of themselves in the community activities section, four of five indicated that they worry, one person every day and another many times a week, about the place where they are living.
None of the residents indicated that they needed help with budgeting money or shopping, although three of the five indicated the need for a lot of help with keeping the house clean, making friends, and getting along with people. Three of five said they needed some help with cooking, laundry, and avoiding emotional upsets and crises. One of the most difficult things for people do, impossible for one person, was 'Joining a conversation' (for three people) and 'Telling a friend that he or she is treating you unfairly' (for four people).

The household was split over the question 'Do you see yourself as a patient?', as indeed was the whole of the patient group in the three houses. Three of five people in Wentworth indicated 'No', although the balance is tipped the other way in the study as a whole, despite most people also considering themselves to be 'fit and healthy'.

Data on the Bipolar Frame of Reference

Wentworth data in the six domains of the frame will be referred to in the order in which they most frequently occur, i.e. if most 'fall' in the Process Oriented to Goal Oriented domain (Figure 6) then that data will be presented first.
Figure 6. A reference sheet for the six-domain bipolar frame of reference, examined in Chapter Five.

1. Process Oriented..................Goal Oriented

2. Discovery..........................Didacticism

3. Intuitive............................Analytical

4. Support.............................Challenge

5. Personal.............................Impersonal

6. Self-Concern......................Responsibility and Caring for Others
Self-Concern to Responsibility for the Care of Others

The Self-Concern Pole

[S6] I think one of the things that's most disheartened me is like going into a house and being greeted by members of staff shouting at residents and stuff like that. To my mind it's a struggle to do what you need to do, which is take them to one side and say 'Look, there is actually no need to talk to people like that. Perhaps if you try this and try that. What's the problem? Why are you shouting?' It's a struggle getting into that.

[S8] On my first day back with the new manager I said to myself 'Keep hope. Don't say much. Listen to what she is saying, and if you don't like it, don't give out what you think.'

[S10] The builders are actually behind on other houses; so all the minor repairs here are ones being given second priority.

[R4] In that case we might as well not be here. I'm gonna spend a week in a hotel.

[R1] Yeah? It can't be a bleedin' whatshisname time merry time for us; those two don't want to make it a merry time!

[S10] I think from my experience the lead-up to Christmas is very stressful. I mean I often find I'm gettin' very very short tempered, very tired, 'cause I've got so much to do, you know, and it seems like when it comes Christmas day is really nice.

[S7] A lot of the staff we've got just don't have the skills to think or, in some cases, I believe don't actually have the will to spend the time needed to put the effort in.

[S6] After weeks of medical clearances and accepted references, the occupational health doctor here ordered me to phone the the director of personnel to say that she had told me that I had to phone him to tell him that I'd been in
psychiatric hospital when I was younger and that he had to phone her to say I'd told him because she said she didn't want the responsibility of having someone throw themselves in the Thames with pressure of work. If that's the way you treat potential staff, how do you actually treat the staff you've got?

Responsibility and Caring for Others

[S9] It would be meaningful if I could sit down and talk to Tom, Dick, or Harry, to find out what's going on with them. I haven't been able to do that.

[S9] We need to understand that this person needs this help. Do we just pretend this person is not showing any signs of needing help? She is! Who do I turn to? Well, there is not anybody, really. There's your team leader, but even as a team we've been saying we should be getting professional help on this now.

[S12] Staff need to administer drugs. Where do we keep it? We have not been allowed to have a drug cupboard. It has been on the kitchen shelves, whatever. That terrifies me because people are vulnerable and we are not being responsible.

[S7] I think the main problem is the communication is not right. You know specific responsibility in your role.

[S11] People are almost frightened to say what they feel themselves unless they have got the backing of a book, or the backing of their boss, or the backing of something else.

Discovery to Didactism

The Discovery Pole

[S8] I don't know exactly what was expected. What is the right and what is the wrong. It's like there was normalisation in the extreme and being very restricted or protective to the residents at
the other end. I didn't have the chance to learn how far you can go at either end. I found myself just thrown in the deep end and I had to start thinking.

[S6] I think we can all at some point fall into the trap of focusing on peoples negative aspects, what we consider to be peoples negative traits have got more to do with our own feelings and problems than they have to do with other peoples.

[S10] We could have an on-going thing using materials like cameras, colour supplements, pictures, posters, handbills, things like that, and it would be for the residents to actually describe their current situation. How they feel about their life. What are the important things, the important places, the important people in their life at the present moment, graphically describing that with posters.

[S9] We haven't even started talking with residents about what's right and what's wrong for them.

[S11] You are really searching for the staff member's inner need. What that person can really do. You are not just saying 'Do this job' from the top of your head. You are saying 'If that person has got the ability within themselves to do this job, let's bring it out.' It's not lying dormant. If it can come out with the listener, then it can be seen, and that person can then use it in his work. He doesn't need to be told all the time that this thing is in there. It's somewhere in him, hiding, waiting to come out, because he has started to experience it now. He's saying 'Oh yes, I'm talking to this person and I feel something different. An ability to cope with situations that perhaps I wasn't able to cope with before.' I think that within you there is the ability to answer questions, and if you listen to somebody you absorb what they are saying. Only if you do that, though, can you come forward with the answer, because you have taken the problem onboard. But you have got to take it. You don't understand it unless you take it. When they have finished, then you have got an answer within yourself to deal with that problem. It's automatic, if we only knew. It's like a tennis match. If someone hits a ball across, you
automatically hit it back, or you try to hit it back. The more experienced you get, you know you are anticipating. It's like that with life as well. It's nature's natural rules. You are playing the game but you are also creating a harmonious thing as well. You can play it that way but you have to be in tune and in touch. And you have got to teach people to be in tune. It isn't something you can understand just like that. You have got to suffer a little bit. You have got to spend time with that person. Like you do. You have got to keep going until you do understand.

The Didactic Pole

[S12] You have to get the right people at the top, right in the sense that they can provide direction, leadership, and communicate the object and purpose of what needs to be done right down through the grades to the person who uses the service so that everyone knows what's to be done and how to go about it.

[S10] Staff morale is down. Staff are confused. This house has been open for a year. There is no procedure for anything. They don't know when they're going shopping. The residents will pay their rent money whenever. And if one staff didn't feel he should be keeping an eye on money, some residents were going for weeks without paying and nobody knew.

[S6] A lot of the information we got from the hospital was damaging to the people we were working with. I looked at one client's casenotes because somebody asked for information about medication and I was horrified at what was in there. A set of supposed assessments that had been done on him and the way they did them, I mean they must be on LSD or something because they had no relevance to the facts as they are.
We need a set of rules or suppositions like 'Clients need to have their own independence, clients need to be self-motivating' and many other things. They are things we need to know. But it doesn't really go very far in teaching us how to deal with situations that come up.

We didn't have direction. Our manager didn't say 'This is how you do this.' We didn't know how to deal with people's money, benefits, with ordinary living in a house.

Process to Goal

The Process Pole

Once you get to know people, then suddenly... there's a blank space...you can't say what you want...it's not a matter of do this, do that. I know she was a good person, team leader, very good, very good indeed.

It may be that each of us has different views as to what we're in the house for, in terms of what kind of service we are there to provide and what we actually do to provide it.

There was medicine in cupboards, in drawers. Everywhere and anywhere. Medicine bottles. I said 'Why don't you keep them in the kitchen, or in the bathroom?' Some staff know when residents are supposed to go to the day hospital, and some staff not. You ask one thing and you get eight different versions.

We could actually look at what is a desirable future for each of the residents--what they would like to see themselves doing for example in a year's time, what they would actually
like in their lives. And they way we could do that would be to pair ourselves— one support worker to one resident. And then we work out an individual agreement as to how we're going to help them.

[S12] There was a man who had been in nursing 30 years and was retiring next year, and yet he had the most humane way of working with people. I've heard it said that people get institutionalised working in hospital, but when you feel comfortable and safe with what you are doing, you lose that with the rules and regulations because you feel quite comfortable in yourself in taking risks.

[S7] Staff ought to be more involved in the selection of residents.

The Goal Pole

[S10] One of the impressions I got when I first met the staff was that there was too much emphasis being put on the administrative side. There are lots of chiefs and not enough indians is the only way I can describe it. Everybody wants to be in on arranging things with the DSS and all sort of bits about the writing of files and so on, but the actual client contact, the going out with people, that somehow doesn't match up. One member of staff would say 'I'll change the light bulb for you. I'll show you how to do it.' And then they'd go off and do something else and that would be forgotten about. Left. Or the toilet seat had come adrift. 'Oh, I can do that' and then they would go off.

[S12] I am very surprised when staff are with clients in a directive and task-oriented way and not actually spending any quality of time in being with people on a level.
[S8] I think just being human, or just being a caring person, this is why I knew I was right but I didn't have the knowledge base to back it up. I always found myself defeated. If I said 'We need to show them how to, say, operate the washing machine', the staff would say 'Why should we?' Or they would have reasons for not doing it. And maybe what I used to do was just to stutter and not say this, that and the other because I did not have the facts. And I find I am getting all this information on my current course, and thinking, 'I wish I knew this.'

Support to Challenge Domain

The Support Pole

[S10] I mean what I tend to try to do if I am supervising somebody and I have to give them criticism, is to try to say, 'I'm not happy with the way you're doing this and this, but I do value you as a member of staff. You have this quality about you and you have that quality about you. I need that in the team.' So that I am not actually knocking somebody down.

[S12] It's something that I have been badgering management for. I was actually told at interview that I could have money for my own supervision. I have had no supervision since I have been here as far as I am concerned.

[R3] It's much better than living in hospital. It's a better environment for one thing. There's not a mass of people around. More freedom.

The Challenge Pole

[R1] ...ah, I think that someone leaving like that...wouldn't be good would it, because you've got so used to her...haven't
we, yes? And I'm blinkin' disappointed, very disappointed that she's leaving.

[BL] What will you miss?

[R1] I'll miss that she is a very good worker. Now then, I do not know what else, way to put it. She is very considerate. Very good worker.

[S6] You know, you get people who come in regularly half-an-hour late, or whatever, and piss about. I had a senior the other day who didn't come in to work and the only excuse they could come up with the day after was that they had forgotten that they were supposed to be working. Which is crap.

[S10] The one thing I have been aware of with the staff team is that they're a bit too scared to impose, and non-intervention is better than intervening too fast.

[S8] We have this policy of normalisation now. Personal choice. Is there choice? Let them decide. I would say to someone, 'Look at John. He looks like a tramp.' Everybody in the main road here knows that that house—that's where the tramps are. Because of John. And they are looking at who else is going in there and they analyse. We don't need that to happen. We can get them dressed like the rest of the community. At least that removes the stigma from them.

Intuitive to Analytical Domain

The Intuitive Pole

[S10] The right knowledge base is what do you do with your own home. When you think about your own lives, what do you actually do with your own life. What are the things you enjoy?
What are the things you expect from other people? What would you expect from yourself and get people to look at themselves. What would you expect if you were in your own home and you had someone coming in to visit you? It's that type of knowledge base that you need.

[S11] I think in this sort of work it is possible to tune in to their needs. It's more than some teaching you get from the head, or from a set of rules. I think there is an intuition, an intuitiveness that comes maybe from experience or maybe comes from a way of life, which you can use. But you must not cut out because you will not be open to a client's needs and what is happening.

[S11] Lots of people have looked at the functioning side, you know, and we know we need to look at the quality of life of clients. You can't just take away the caring side and the intuitive side and look into the client and see how the client ticks. They used to call it psychology, but I am not sure that's the right word. Whatever you want to call it, you cannot just take away the intuitive side and say it doesn't exist any more.

[S7] There are some areas that I am underused in. Probably the less practical side. It's more the airy-fairy side described in the job description. Things that demand personality. Because that's how I feel about the job, about you know I don't have degrees or anything so I rely on my personality.

The Analytical Pole

[S6] To actually get most basic things done you need to deal with the system. And that proves time-consuming and so arduous, a lot of the time that it does actually take a lot of time away from dealing direct with the people in the houses.
These are not normal people. As much as we want them to be normal, they are very different and so we should know where to begin. You can begin at the top where we could give them more freedom. Maybe we should be restrictive from the beginning by the aim being educating and letting go slowly as the people become more skilled. That is what I think workers should be aware of before they come to the house. Once they come to the house, they pick up the bad habits which had been going on and it then becomes very, very difficult to change it. Catch them before the damage is done.

I can either just bluster my way through and pretend that it's not really happening at all, go into Cloud Cuckoo Land, or try to find some way to get the skills I need. But that requires, actually, a bit of thought and a bit of self-assessment. I think that is something that people in the team are quite bad at. Self-assessment. Because they've never been in that situation before. It's not really critical to them. It's like asking somebody to drive a car who has never driven before.

Personal to Impersonal Domain

The Personal Pole

You need to try things. Learning has always been that way. I mean even a baby crawls until he can walk. He falls over, but he gets up again and he keeps trying. The kids do it all the time. 'What's this, what's that? What's this, mummy? What's this, daddy? How do you use this? How do you do that?' If parents just said, 'Nothing. Nothing. Nothing. Nothing', what would be learned?
The Impersonal Pole

[S7] It's very very difficult to actually sit down and talk to any individual resident. There's nowhere to go really except the sitting room. So if you're fortunate and most people are out and maybe there's one person in, then maybe you can.

[S6] As far as work that's been done with people, after a year at Wentworth there's very little work been done with people. It's a combination of two things—staff's ability to think and communicate with people about what's needed, and then it's about their ability to actually carry that on, think about it, develop things, chase up things, stick with things.

Data in the Moral Grid

Presentation of data is also in a narrative format, quadrant-by-quadrant in the moral grid (Figure 7).

Constructs are placed in a critical framework to apply a constructivist method of accounting for analogous expressions. That is, a characteristic of construing may be that it is bipolar, or dichotomous, having both a meaning and its opposite in different contexts.
Figure 7. A reference sheet for the moral grid, examined in Chapter Five. The axes of the grid represent degrees of high to low expressivity (E) and high to low structured domination (SR).

**E**

**HIGH**

1. There is a lack of care for the capacity of another individual for personal discovery. A person's experience is disregarded or re-framed on the experience of those in power.

2. The imposition of control. Considerable restraints on the part both of those who do and those who do not have power. Confrontation is generally avoided.

**SR**

3. Individuals state their interests and desires, perhaps, but alienation is observed, in contrast to integration.

4. There is an ideal of equality and mutual respect; but the scope of experience to which these ideas apply is greater than in Quadrant 3.
Quadrant 1

[S10] You have to speak your mind sometimes don't you Jacob [who responds by looking away from the support worker].

[R1] Well, he's a bad character [says Harry about John], he won't do as he's told [interrupted by a housing association worker entering the meeting]

Hello, sorry to interrupt but I've just seen Marie and I had to look at the carpet and somebody from the insurance company will come around okay? [interrupted]

[R1] Yeah, she's ah sick [interrupted]

[S9] What and where am I putting my input, where's it going? Am I doing enough here or should I be elsewhere? I don't know what it is but there's a problem with Wentworth Street. Fielding Road is a completely different story. But even if Wentworth is a small house, the residents are still there and they need staff working there. As I see it we need to move people back to Wentworth 'cause I can't do the work on my own, it's impossible!

[S7] So even basic things are getting neglected because whatever the problem then the lack of support from staff is causing other areas to be neglected when people prefer to work in another house.

[S6] In fact a comment that was mentioned the other day was that nobody's died yet and the general feeling is that that is more by luck than management.

[S6] At the moment there is just no space for really being with people because there is such a basic need for very, very basic things. Whether it be through writing things, or speaking things,
or whatever. There are some people who just can't do it. It's the lack of ability to communicate with people you are working with. Staff have the same basic problem as residents.

[BL] I feel that I'm seeing too much of this pre-dominating, directing, ordering about of residents.

[S10] I'm not happy about the way it's developing. One of the concerns I have is that we could turn into a baby-sitting service. Some staff feel they are housebound and that is their job. You know, to make sure that the washing up is done, the cooking, the cleaning, paying the rent, that residents go off to whatever classes and that's it. That's the extent of it. That's a very very restrictive way of working with people, but that's what I fear is happening.

[S9] We must come to realise that we cannot let the service run in that manner, where staff are employed just to come and look at the residents destroying themselves. We've learnt a lesson from Marie and John and what Wentworth was becoming.
Quadrant 2

[S10] I just rather wonder how you know this is turning into very much almost an encounter group with people confronting each other and initially we started off as a team meeting where we were identifying strengths and weakness. And I think that, you know, we've gone away from ways of working and we're now getting into interpersonal conflicts.

[S7] It's crazy 'cause you're tryin' to steal time to go to Wentworth. And when you do go you've got something specific in mind. Like I've got to see Marie and make sure she's had her tablets. You time it and say 'I've got half an hour to talk, make some lunch and make sure she's had the medicine. It's pure mechanical. It ain't right.

[S9] I come in with my coat on and I don't take it off because soon I'm gone. Or I pop in to use the telephone. That's another thing that's really driving me crazy, because there's not a telephone as at Fielding Road. You might as well be in Timbuckto when you go in there 'cause you can't contact the outside world at all...and I'm not going to pay ten pence to use the phone!

[BL] How would staff learn about the things you've said they should be doing but aren't doing, that is showing commitment and will in their practical work with people?

[S6] I don't think they could learn from me in the sense that I think things are at such a crisis point with the staff and the way things are generally that I don't think I have actually got the skills to be able to do it. I have this belief that if people are getting paid they should be able to do the bloody job! A lot of them don't
seem able to. That's nobody else's fault but the people who recruited them. It's not the staffs' fault. If you hold up their person specification against some of them, I don't see how anyone in their right mind could even think that these two just don't balance at all.

[S10] You've got three senior support workers at Wentworth, all of whom expect to have more responsibility and all of whom are pretty good at thinking up ideas, but putting them into practice...you know, it would be better if you had a better mix of staff. If you had some doers as well as some thinkers.

[BL] Is it a question of the right 'grades' of people?

[S10] No, it's the type of people who are recruited. You have to have a mix, not so much the ones who have got all the knowledge there, or the experience there, but people who, perhaps, are more willing to roll up their sleeves and get stuck-in to doing something. Or just being friends and going out somewhere. Bringing some of their own friends in to work.

[S12] We felt like toads or something, telling people to 'take a walk'. Some of it has to do with space. Physical space. I think that is for clients as well. Coming from huge, great open space, where they can get away from other peoples' behaviour, and get out and go take a walk in the grounds, where they are still secure. It's very different here and I think alot of people forget about the geographical re-location and what it means to be in a small house.

[S8] I had to laugh. I said 'If you have been doing this all the time, working residents under duress, they don't want to do it. These people are pensioners and you still want them to get up every morning and mop and hoover and so on. If it was your mother, would you like that? Isn't it time they should be resting?"
Quadrant 3

[S10] What do you think about that Vera, what Marie's suggesting?

[R2] I don't know, ah, but [interrupted by Vera].

[R4] Have a think about it then! [said to the team leader] We're only making Christmas cakes.

[S10] Are they iced Vera as well?

[R1] Thank you, thank you, I, I wanted to make them understand that ah to keep the place in good order up there. You know smoking a lot, placing in ashtrays on the floors, which I have seen them do in the hospital and they stub it out on the carpet. And that's [interrupted].

[S10] Harry, can I just say, Marie and John have been asked not to smoke upstairs.

[R1] Yeah, I know they have but [interrupted].

[S10] Yeah, by the supported housing manager.

[R1] I know, I know [interrupted].

[S10] And I think, you know, on that score since we've had a fire upstairs [interrupted by Harry].

[R1] I think, I think it's John that's the cause of all this 'cause [interrupted].

[S10] Listen, Harry, I know you think it's John a lot of the time but what we're actually asking all of you is to actually say to them 'Come downstairs you have already been asked to do that. Okay, don't smoke upstairs.' I mean we'll back you up, we'll support you with that. Because yes, it's difficult.

[S6] I think one of the most difficult parts of support work is to actually empower somebody else. I mean you do leave yourself wide open. You have to take a step back. If somebody says 'No' to you, 'I don't want to do that', what do you do, how you cope with it? People who come from the
hospital are used to being told what to do. It takes quite a while to work through staff actually getting to the stage where they can initiate things when it's the right moment and yet stand up and let somebody make the decisions, take the risk of going out, or doing the cooking, leaving them unattended. It's that big grey area. There is too much emphasis, I think, put on chores, on actual skills. Far too much emphasis. It's quite difficult to actually get that across to staff that there isn't a need to have one in control, one in power, without them feeling threatened.

[S12] Talking to people who have moved across, they are actually feeling quite de-skilled. This is nurses and non-nurses who have moved from hospital wards to supported housing. They have lost their identity and have nothing to put in its place. Particularly for the qualified nurses. Wanting to give injections to people in the house, 'Well, we might as well do it. We are qualified nurses. It saves using the resources elsewhere' and arguing with them about that, that the relationships are such that we don't want to go sticking needles in people when we are trying to be their friend.

[S7] Most of my difficulties are as a person working with others, not strictly to do with the clients but with other staff.

Quadrant 4

[S6] Maybe we should pool all the key issues around people and look at what needs to be the priority, writing down key issues, collecting that information together and examining it. Then the team leader sets the priorities, if needs be, and handing it to a person and saying 'Well, this needs managing.'

[S9] It's quite complicated really when you come face to face with a person who you don't know very well, who you've only had limited experience with,
as to how much authority to exert when you're there to do something with them. 'Would I do the same as another staff member? Will I be able to because I don't know a client as well as that staff member does?' And I, whatever way I did it, it would be different from the way you did it, but would I actually do it? Maybe, maybe not; maybe I wouldn't feel I could. But anyway, we could address the issues.

[S7] How do we maintain our sense of commitment and our motivation and our excitement about the work unless it's our interest in each other as co-workers. It would be a shame to lose that enthusiasm because the people who we serve then might suffer even more.

[S8] Before anyone walks into these houses, what they need is a framework of things that they are expected to be doing. Like, treat this like your own home. Yes, it is not your own home, but treat it like your own home. And these residents like your parents or your grandparents.

The researcher's observational data of Wentworth Road is included as an interpretative aspect of the analysis chapter that follows. Apart from this, the data presented is a selection of the weeks and months of video-recording that is subject to practical constraints, e.g. of transcription time, mechanical distortion with the equipment, and personal constraints, e.g. work or social commitments that changed the availability of participants. Permission is given for the unpresented data to be used for
educational purposes, in consultation with the research participants. The video-recordings are of significant value because what is conveyed may be more than words can describe and, of course, their authenticity is permanent.

Further data from the structured questionnaire and reporting on the configuration of data will arise in the later chapters, as the exponential effect of data, referred to earlier, is realised.
This is the first of three analysis chapters, each of which will follow a similar format. The interpretative nature of a constructivist approach, while congruent with data that is based upon personal theories, requires self-scrutiny. The researcher uses himself to study the person as method in investigation. This is, in constructivist terms, a self-organised approach to learning and personal development. While participants are also reflective, the researcher has identified an approach that is open to self-discovery, which may advance an intuitive method prevalent in the data.

A Critique of Judgement

Analysis has been described as a 'craft skill' which takes time to develop and is slow to conduct (Antaki, 1988, p. 182). An important influence upon the emergence of analytical method, in the process of a constructivist approach to research, is the close personal attention required, particularly intense during data collection and
transcription. Being absorbed in the life experience of other people left the researcher feeling disassociated from his staff development tutor and educational advisor roles, outside the research. This may be evidence of becoming disempowered and less a stranger and more an authentic participant. The personal immersion required to conduct research that acknowledges multiple constructs, multiple realities, is an experiential validation that there is regularity only in the variation of constructs. This comment is by way of reporting that the person who is the researcher is himself a significant aspect of the investigation of a constructivist approach to self-discovery. However, analysis may replicate the investigative process of being person-centred by retaining the researcher's immersion throughout the study.

Data have been presented from five sources: semi-structured interviews, structured questionnaires, exit interviews, two house meetings and two team meetings; a sixth source, fieldwork observations, is contained within this chapter. The process of recopying the words from video monitor to computer monitor, typing them with my fingers, remembering the sounds of the voices, the inflections, watching and re-watching the gestures, seeing people next day and next week and next month, retrospectively self-assessing what the researcher is doing and how he is
doing it...reflects my intention to pursue a dual perspective, a tight and loose focus, that is characteristic of constructivist thinking. Mental illness as well as mental health contains evidence of dichotomous thinking, i.e. representative of a tight and loose focus. For example, manic depressive illness is commonly referred to as being a bipolar state.

One perspective is of the participant observer seeing people and hearing them as exemplars of a particular epistemological position, e.g. the position of constructed knowledge, or discovery, or alternatively of received knowledge or didacticism, or not an exemplar of either. The other perspective is being with people, touching, sweating together in the hot summer of the main study, listening to and seeing this experience during the instance and recording those moments to see a person's whole experience over the year--whole in terms of the whole of individual and collective evidence. The two perspectives are intertwined as a constructivist double-helix of research and practice, illustrated in Chapter Two, and are, in that way, unified rather than dichotomized. The researcher is examining this approach with a view that it may provide an alternative to conventional approaches that maintain the dichotomy in illness and in health.
The researcher's judgement is also instrumental in operating the moral grid and the bipolar framework of six domains. Apart from judgement, the mechanism is straightforward. Making the judgement is (i) a factor of being connected to and immersed in the research and (ii) using a constructivist approach to inquiry as a personal tool, or method, of being open to identifying the questing of others. Therefore, an idea in the data that suggested 'Self-Concern' at one pole, in contrast at the other pole to 'Responsibility and Caring for Others', for example, would be assigned a code for 'Concern for self'. Subsequently all such exemplars of data were grouped together.

Hunt (1989) describes an existential position, where multiple realities exclude any consensus upon reality. The researcher finds himself using the 'subject-object dualism as a heuristic device' in the analysis of data (p. 20). The researcher's judgement is inextricable from the rules of analysis, albeit the personal effect of being the person-as-method results in his self-objectification, as already mentioned. My involvement in a constructivist approach to self-discovery has 'found' an existential position.
Judging from the early chapters of the thesis, a constructivist approach that emerges from a cross-disciplinary search is probably distinct from one that emerges from a particular profession or academic discipline. However, an effect of mobilising the multi-disciplinary literature to focus upon an educational interest in self-discovery, as it pertains to community mental health care, forges an open paradigm that contradicts convention and personal inclinations. I found a struggle too, as participants put it, 'you need the backing of a book' when in essence 'it's not a matter of do this, do that' but it is a matter of working with the 'blank space' of the unknown outcome, rather than at least being able to predict the structure of an outcome.

While there is a 'sense' of homogeneity among staff and residents in the personal profile section of the semi-structured interview and structured questionnaire data, there is an emerging heterogeneity between them as the interview questions and video-recordings of unstructured meetings progress. If the data had not been processed through the two bipolar frames of reference, and if the

The Process of Analysis
questions were not open to individual constructs, the data would remain as homogeneous as basic statistical data, e.g. from age, sex, qualifications, could substantiate.

Were the data to be classified, analyzed, and combined no differently than species of plants, for instance, knowledge would be dependent upon the representational language structure of classification, without being able to integrate the process of representation itself.

An Interpretation of Data

Having discussed an 'attitude' toward the data as being similar and dissimilar, there are significant influences upon the varying characteristics of the staff and residents as groups, i.e. above and beyond a statistical difference, e.g. 33 years is the average age between the two. Team leadership of Wentworth changed hands three times in its first year. Overall management of the supported housing project was held by three different people during the main study.

The age variation also possesses a notable significance, beyond life experience, from a constructivist point of view.
It points to analogies that represent the difference between sanity and insanity, between community and hospital life, between constructed knowledge and received knowledge.

There are signs in the data that although they have discrete identities, the staff moreso than the residents tend to point at external-to-themselves sources to illustrate a personal theory about their life. The meaning that I derived from what we shared is in brackets. For example, two examples from the staff are 'Some residents were sold to us' [by people who did not know but could have known had they asked me just how much living here would have affected John and Marie and all of us, because I actually lived and worked with them in hospital; why not involve me?], and 'The residents are still suffering' [unnecessarily, if you ask me, because I have not got either the co-operation, the consistency of approach, or the will from other people to pay attention to the most basic difficulties that clients here are having, like getting muddled up with their medication, or their money]. Two residents examples are Vera's 'I don't have conversations' [and although it's completely inexplicable as far as I'm concerned I am like the veritable fly on a wall who only lives on the edge of peoples' sight and, as Jacob, a co-resident, put it to me in sharing his view on social occasions, existing on the periphery of gatherings and slipping away].
A second residents example is Harry's 'I think me illness made me blank' [and although I'm not blank now I have this effect of having been blank that means I have this momentary pause and I have to work out in me head a good way ahead of the time that I actually speak what am I gonna say so that when I have done that I'm so far behind the others that what I intended is erased].

In what appears to be a straightforward, if not superficial, explanation of domestic-centredness of staff, there is a tension between the individuality of knowing and the wanting to know how to provide a more personally satisfying service. The initial evidence for this tension comes from the semi-structured interviews and is embodied in the team leader's expressions of having to find 'what is right and what is wrong' [because you get a measure of what is right from your experience of living and growing in a house with your family and finding by trial and error where you go wrong and the kinds of things that you have to do to keep on the right track] and expecting the staff to find a 'half way' [by using this measure from their own life experience to achieve at least a position in between right and wrong].

However, the second team leader of Wentworth found that the domestic-centred focus of support workers was turning the
staff into a 'baby-sitting' service [by treating the residents as being disabled from doing ordinary things to the standard required, according to the personal measures of homeliness by staff, and as a result residents may believe that view although it's never spoken but conveyed day-in and day-out by what the staff do]. If staff deprecate the ways in which residents think, act, and feel, it may also discourage them from cultivating their capacities for self-discovery.

A powerful 'Self-Concern', e.g. 'staff shouting at residents', 'it can't be bleedin' whatshisname time merry time', strikes the informed observer as complaint about the unexplored ground between 'Self-Concern' and 'Responsibility and Caring for Others' (Figure 8), e.g. 'I haven't been able to find out what's going on with them', 'communication is not right', 'people are frightened to say what they feel themselves unless they have got backing'. There is a consistent force for a will to know and to know how to be with people such that domestic work might take on a different meaning if there was an answer to such questions as 'What do you do, how do you cope with it...if somebody says to you No I don't want to do that?'
Figure 8. A reference sheet for the six-domain bipolar frame of reference, examined in Chapter Five.

1. Process Oriented..................Goal Oriented

2. Discovery..........................Didacticism

3. Intuitive..............................Analytical

4. Support.................................Challenge

5. Personal.................................Impersonal

6. Self-Concern.........................Responsibility and Caring for Others
There is evidence that a knowledge already resides with the staff group, albeit the knowledge-base is diffused mainly in domestic work. The act of becoming a knower is alive to the search that comes from inside people, as these messages would testify:

[S11] It's more than some teaching you get from the head. You are really searching for the staff member's inner need. What that person can really do. If it can come out with the listener, then it can be seen, and that person can use it in his work.

[S6] What we consider to be peoples negative traits have got more to do with our own feelings and problems than they have to do with other peoples.

Yet there is a need for parameters, boundaries within which discoveries can be made, e.g. 'We need a set of rules or suppositions', 'staff are confused', 'We didn't have direction'.

The means to this inside pole of knowing, of self-discovery, involves the hypothesis that 'each of us has different views as to what we're in the house for', 'when you feel comfortable and safe with what you are doing, you lose that with the rules and regulations because you feel quite comfortable in yourself in taking risks'. A goal oriented
approach to knowing fails to provide a satisfactory end to
the process:

[S10] Everybody wants to be in on arranging things... but the actual client contact... that somehow doesn't match up.

[S6] Staff are with clients in a directive and task-oriented way and not actually spending any quality time in being with people on a level.

There is a commitment to discovering how a person can help with that 'blank space' in peoples lives, where:

[R1] Once you get to know people, then suddenly... there's a blank space... you can't say what you want... it's not a matter of do this, do that.

A collective view is contained in Quadrant 1 of the Moral Grid (Figure 9) about not attending to the job as one would wish:

There is no space for being with people | Some staff feel they are housebound and that is their job... that's a very very restrictive way of working with people | We cannot let the service run in that manner, where staff are employed just to come and look at the residents destroying themselves | So even basic things are getting neglected | What and where am I putting my input; where's it going? | Nobody's died yet... more by luck than management |
Figure 9. A reference sheet for the moral grid, examined in Chapter Five. The axes of the grid represent degrees of high to low expressivity (E) and high to low structured domination (SR).

<table>
<thead>
<tr>
<th>E</th>
<th>SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>HIGH</td>
</tr>
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<table>
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<tr>
<th>1</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a lack of care for the capacity of another individual for personal discovery. A person’s experience is disregarded or re-framed on the experience of those in power.</td>
<td>There is an ideal of equality and mutual respect; but the scope of experience to which these ideas apply is greater than in Quadrant 3.</td>
</tr>
</tbody>
</table>

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<tr>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>The imposition of control. Considerable restraints on the part both of those who do and those who do not have power. Confrontation is generally avoided.</td>
<td>Individuals state their interests and desires, perhaps, but alienation is observed, in contrast to integration.</td>
</tr>
</tbody>
</table>
People are hypothesizing with the analogous thinking that supports their personal knowledge and experience. The data may indicate that without a methodology, or procedure, for actually testing out for themselves what they think, dilemmas arise for them because their questions remain unanswered.

Dilemmas are posed in Quadrant 2, with reflective repose:

- I had to laugh
- We felt like toads
- I just rather wonder how you know
- I don't see how anyone in their right mind
- If you've been doing this all the time, working with residents under duress
- That's another thing that's really driving me crazy

Personal domination by those in power of the self-interests of others is evident in the data presented on Quadrant 3. The genesis of argument and the stating of positions is also apparent. Hospital staff who work in supported housing are said to have 'lost their identity and have nothing to put in its place...we don't want to go sticking needles in people when we are trying to be their friend.' In this case, the analogy is one of a nurse who gives injections on the one pole and its opposite, a friend. These dichotomies are problematic and beg the question of whether an alternative approach to the 'how do we do this' type of question could create the mental space to allow workers to think through their responses before, in the event of attending to a resident, an intuitive reaction disappoints them.
'To empower somebody else' is posed as 'one of the most difficult parts of support work' and yet 'far too much emphasis is put on chores...there isn't a need to have one in control, one in power' without staff feeling threatened. These words in the same 'breath' from the worker who asked the 'how do you cope with it?' question, indicating the answer is within, given a methodology to connect it with practice. Referred to by staff as 'This big grey area', the question is how to know when to 'initiate things when it's the right moment and yet stand up and let somebody [a resident] make the decisions, take the risk...' In contrast to the profound statements of Quadrant 1, Quadrant 4 produces a vision of going forward and investing in an exchange of personal experience and knowing. Pooling key issues, is mentioned, along with addressing the issues raised by the 'complicated...face-to-face...experience':

how much authority to exert...would I do the same as another staff member...would I be able to because I don't know the client as well... and I, whatever way I did it, it would be different from the way you did it, but would I actually do it?

The critical alertness to discovering what to do in support of residents, and particularly what is right, is understandable in the context of unanticipated staff changes inside and outside the house.
The Wentworth house and team meeting data that was given in the autumn, as well as much of the exit interview data in the present chapter, occurred in the context of (i) the dismissal of the 'overall' manager of the supported housing project on a Friday in November, and her replacement starting work on the following Monday, and (ii) the resignation of the second team leader of Wentworth the following month. The collection of semi-structured interview and structured questionnaire data was followed by the resignation of the second 'overall' project manager in the spring. She left six weeks after her decision to send John and Marie back to the hospital. Criticism had followed her unanticipated 7:45 a.m. visit to Wentworth. The couple were returned to separate hospital wards on that day.

Participant Observations

Contextual descriptions from fieldwork observations are interpretative, pre-existing analyses, recorded at random intervals on eight-by-five inch file cards. They do provide evidence of the context from which the data was taken. They serve to maintain a link between the concrete and the abstract in the analysis.
The following extract is derived from a meeting of staff the evening before, when the announcement about John and Marie was made:

It felt like, and was said to be, a 'tragic' moment for residential care; the service had failed them. There were profound objections, especially from the key-worker. It was clear that the decision was made four days ago... 'We told them it was for life', someone said... I was surprised at the report that the keyworker was asked to produce, which contained a long list of failures and deficits, particularly where John was concerned, e.g. his running away on ten occasions and staff having to fetch him when the house first opened over a year ago. However, when I asked about it, the keyworker said it was only what she extracted from the notes, which is either what the staff are centred upon, or what they think they are expected to be recording.

The staff asked in the early autumn that a training event be scheduled in November, to address issues that the staff and residents were experiencing with 'untidyness' in the house. This was cancelled, as indicated by the fieldwork note extract on the 9th November:

My impression of the staff, given the sense of alarm and conflict in the patient group about John and Marie, was one of disinterest. One senior support worker might come in tomorrow, when he should be off. Another had a personal appointment today. A third was off to visit his girlfriend. Considering this had been planned and the residents consulted about it in some detail, the staff seem rather uncommitted. The team leader explained that Marie had been unwell and as the result, along with sleeping-in at another house, they were now short
of staff. She had taken three days off prior to today and had, with the staff, forgotten about the arrangement. As it happens, the residents have decided not to be with the staff, or us, excepting, that is, Marie and Harry.

The next two-day event to address issues of concern in the house, in January 1990, was cancelled by the acting team leader 'because 26 weeks of annual leave had to be fitted into 11 weeks'.

Tension in the group was noted during a June 1989 house meeting:

The team leader talked about sleeping-in the house for these few nights to help look after Marie, and she brought up the subject of tension between Harry and John and Marie. At one point Jacob exclaimed, 'You're trying to make us into all friends and we're not!' The staff are concerned about order and standards of cleanliness in the face of verbal attacks by Harry upon John, relating to the disappearance of food and the latter's household habits.

The circumstances in these examples of contextual changes in the arrangements inside and outside of the house, elucidate the complex ways in which breaks in communication and understanding occur. The complexity and problems for self-discovery are amplified when these fieldwork observations are considered alongside the personal theorizing demonstrated in the earlier analysis of this chapter.
Unanticipated interruptions, for example, or distortions of a personal point of view, transform people into objects of one another's domination. In this light the staff view that residents are 'suffering' seems more a point about their own wish to know what to do about it, given the data in the bipolar frame of reference and moral grid.

A Reflective Statement

The sequence of collecting, transcribing, and delivering the data to presentation, involved judgements by the researcher, on his knowledge and experience of the investigated people. The impression of the stranger was evoked. The data acquired a direction that was checked and transferred on at each stage of its life as data, to corresponding points on the six bipolar domains or on the four moral grid quadrants. Given the analysis, the question arises in his mind about the reality of a stranger among strangers, i.e. whether the deconstructed data of a constructivist approach represents an existential fact of life.
CHAPTER EIGHT

DATA FROM SHRUBLAND LANE

Compared with the four exit interviews at Wentworth, there is one 'leaver' among staff at the Shrubland Road house. Other differences in data sources are four video-recorded 'triads' at Shrubland, where the researcher, a keyworker, and a resident meet together, at the Shrubland house. Like the 'unstructured' exit interviews, the triad sessions explore current interests and issues in a way that may facilitate self-discovery. An elaboration of the personal methodology at work is in Chapter Five, particularly in the Fieldwork Relations section. Data sources that the two houses have in common are the semi-structured interview, the structured questionnaire, and the video-recorded team and house meetings.

The average length of time in mental hospital for the four Shrubland Lane residents was 21 years, seven years longer than the average in-patient time of the five people who lived in Wentworth Street. Three of
the four people whose evidence is represented in this chapter were single, while the fourth was married but living apart from her husband, who lived in a nearby hostel and visited Shrubland once a week. The average age of the two men and two women was 56 years, seven years less than the average age of the Wentworth Street residents.

Three of the Shrubland staff were 'trained' psychiatric nurses, compared to four at each of the other houses (eleven nurses among 23 staff). One of Shrubland nurses resigned two months after the house 'opened'. The average age of the staff group was 30 years. In contrast to the untrained staff group in the Wentworth Street house, the other five members from Shrubland Lane had no experience of either mental hospital life or being with a person who was a patient.

Staff Perspective

Qualities in people who do the job of support worker are listed in the collective response to the question
of 'What is most important to you in doing the job you have to do here in the house?':

Care. . . Commitment | Patience and understanding. | Sense of humour, understanding. | Tolerant. Support. | Empathy, genuineness and a hope for better things in the future. | To realise potential and ability of residents. Not to expect too much or pressure people into tasks beyond their capabilities. | Insight and understanding of the needs of people who have mental health problems and who have spent a long time in hospital. | To show interest in the well-being of the patients, make yourself ready to listen to them.

In contrast to these views, the senior support worker [S23], who resigned, and the team leader [S17] indicated rather different constructs of what was most important:

[S23] Have the right staff, rather than face a team being in discord and conflict. Select the right residents for the right houses rather than face the same discord and conflict amongst residents. [S17] A thought out structure with appropriate facilities applied consistently.

When asked what work they do in the house, staff cited a range of examples:

[S24] It's a combination of practical and emotional support—anything from dealing with benefits, fixing up appointments, helping with social skills—cooking, cleaning, whatever. Giving residents constant emotional support.

[S18] It's everything from cleaning the toilet to counselling.
[S17] I run an interference function between the staff and the clients and management at the hospital and its system, to block the excesses of unthought-out interferences in peoples' lives.

The question about groundrules elicited a mixture of principle and procedure, e.g.:

[S21] Make sure people have their medication. People have three meals a day. Ensure the house is very very clean. Ensuring the whereabouts of people is known. Plus basic health and safety.

[S18] You have to respect what they want out of life. Not what you think they should have.

[S22] You have to be punctual every day. Most of the patients smoke and you have to make sure they don't drop the end of cigarettes onto the carpet.

[S17] It's about empowering, about increasing freedom of choice so that the clients--and the staff for that matter--know the consequences of the decisions they are making.

There is a contrast in the staff group between self-assessments of what is difficult and theories about the context of the work, e.g.:

[S17] There is no consistency of approach. The house had been running for six months, the client priority was abandoned and financial priorities came to the fore.

[S18] When they have no interest and have no motivation I find that very hard. I tend to take that personally.
[S19] The type of work. I am in a team meeting and know in my head what I want to say and sometimes I can't bring myself to express it. Maybe I don't have the confidence, but it's something else holding me back sometimes.

[S20] It's hard to know where to actually intervene. You don't want to impinge on their privacy, their lives, and it's hard to know where your role is. How far do you stand back and how far do you actually say, 'Well, this is actually how things have got to be done.'

[S21] It's difficult to cope with people who have some mental health problems who might be being abusive towards you. Being personal, you know.

[S22] When Peter isn't in a good mood and he's a bit aggressive and you are a bit scared it's going to happen. Is he going to strike, or whatever. Sometimes transportation is difficult, especially when you live far away. That's my greatest difficulty at the moment.

The final question of the semi-structured interview asked about changes for improvement:

[S17] I would like to see the office base removed from the house, because I think that is an unacceptable intrusion into client space.

[S18] I find that I take time away from the clients, or bully or push clients to do cleaning that they don't want to do. I see my role more as helping them to achieve what they want, not 'Oh, here she comes.' I don't like that part of it.

[S19] I'm a great believer in clients not sitting on their bottoms, and this tends to be the case, although I do understand that these people are having a new experience in their lives. I sometimes think the clients are
treated like children, or idiots, or as if they're not capable when they are.

[S24] I think age of staff is very inappropriate—all young and middle class people working here.

[S21] I think there should be two staff on. I would like a staff team to meet. There should be more facilities for day services, and I don't think they should be allowed to sit in the house.

[S22] I would like staff to have unity, to work as a team. I think you should do this by way of respecting people, accepting them as they are, and working together.

Residents Perspective

In response to the question, 'What is most important to you living here in the house?', the collective response was succinct:

I help in the house with the meals and that. | Well, it's cooking and cleaning; it's like living a normal life. | My freedom. | Paying the rent. Cooking and general hygiene.

These points are elaborated in brief descriptions of what life is like:

[R13] It's a nice house. I've got a room of my own. You can have a cup of tea when you like.

[R14] Life's beginning to become a strain on me and I didn't realise what effect it had on me before, until I did when we first came here. In the other group home the men did
their own cooking and cleaning. But these two men are different. I can't do it anymore. I can only look after myself. Otherwise, the house is lovely.

[R15] It's a sort of small group home connected with the hospital. It's very good. A bit different to the hospital. It's more environmental. More into sociable outside.

[R16] It's good to be round the house, that's all.

The residents of Shrubland put forward a procedural view of groundrules for living in the house:

You pay the rent. We have meetings. | We have to do things they arrange for us. | To keep your place tidy. | Fire practice. Turning off lights. Learning about gas appliances. Not making a nuisance of yourself.

These thoughts are further elaborated in the context of thinking about differences between the house and hospital life:

You don't need to be told what to do. | It's better; more modernisation in the house. | It was easier at the hospital because our meals were cooked for us and we didn't have to go miles up to the high street and miles to see a doctor.

One of the residents [R14] reported having difficulty living in the house:

Well, the men don't say, make demands, but nobody cooks for them, you see. They keep slamming the door and I thought it was that
reason, but I don't think they have said anything. They haven't asked me to, but they wait. I don't think Graham can do his own cooking.

One of the residents [R15] said there was more to be known about before the move:

I should have got a job, in a firm or something like that. I know all the coins. I know all the notes. I know the things like that, so I should think reading and writing. Literacy and art.

The other man in the house said he 'didn't know I was moving until they took us to see the house. It was quite a surprise to me.'

Similarly, only one person [R15] had a view of what would have changed 'if life were better tomorrow':

It is something to do with the spiritual. Religion is important. But I don't believe in going to church much. That's the funny thing. You can believe to a certain degree. Not quite so much. But you can believe.

The Structured Questionnaire (Appendix IV)

The response to the last question of the semi-structured interview is offset by the residents response to the item 'worry about your future'. Three out of four indicated that they worry from a few times
a week to every day. Two people said they worry about money—in one case, 'many times a week', and the other person 'every day'.

However, all four residents indicated that they 'almost never; worry about the place where they are living. Whereas, at Wentworth Street worry about living in the house varied from 'a few times a week' to 'every day'. Shrubland residents expressed a higher degree of satisfaction with the 'where you are living right now' than did Wentworth residents, although one Shrubland resident was 'very dissatisfied' 'with the help you receive when you are really having problems or are in a crisis'.

The open-ended questions which followed yielded self-descriptions about what they liked best and least:

| Bedroom. | Cooking, bathing (hygiene). |
| Freedom. | My room. |
| Cooking. | Having to over-work. |
| | No freedom (moneywise). |
| | Peter's radio and smoking. |

Along the one-to-ten scales that describe opposite feelings, the Shrubland residents differed from the Wentworth ratings on one of the four scales. Along the
scale that represents concern about health during the past month, two people indicated at mark eight and ten, which is 'very concerned' while the other two Shrubland residents and all of those from Wentworth were mid-scale and below.

As with the Wentworth residents, people at Shrubland were divided on the question of the surnames of other residents in their house, i.e. two knew and two did not know. Three people viewed themselves as patients, compared with two people at Wentworth.

Data in the Bipolar Frame of Reference

The six domains of the frame of reference (Figure 10) is one of the two data processing techniques used in the constructivist approach that is investigated in this study. As indicated in Chapter Five, these are infrastructures to contain data that is amorphous and ever-changing. The constructivist nature of data is illustrated in Chapter Two and discussed in Chapters One and Three. The data is therefore a 'snapshot' in time that is 'enlarged' for study by the use of a frame of reference.
Figure 10. A reference sheet for the six-domain bipolar frame of reference, examined in Chapter Five.

1. Process Oriented ............... Goal Oriented

2. Discovery ......................... Didacticism

3. Intuitive ......................... Analytical

4. Support .................. Challenge

5. Personal ....................... Impersonal

6. Self-Concern .......... Responsibility and Caring for Others
Self-Concern to Responsibility for the Care of Others

The Self-Concern Pole

[S23] Being a survivor and knowing from experience how important it is to be in touch with reality, have friendships and relate to the world around me.

[S18] The money was getting in a mess but we had some trouble with him about his room and keys. He said staff were getting into his room and stealing things. So, we thought no way. And stealing his money as well.

[S21] I find it extremely difficult just sitting in the house and know how to make best use of my time if people don't want to do anything and just want to spend some time in their rooms. It's not very pleasant at all. It's very lonely and boring.

[S20] I've just done a sleep-in, so when I go home that's a 25-hour shift on my own. Which I think is quite a long time. Too long really.

[S24] Frankly, what we are being told is that if there is trouble cover yourself. That's what is being turned into a staff oriented service. Fair enough, I mean we're working with haphazards. There are some situations which we would be in trouble for. But you can't strip the residents of everything they have.

Responsibility and Caring for Others

[S18] No, but I mean if you stay out all night could you give us a ring to tell us you're alright, if you're not coming home all night?

[R16] Yeah.
[S18] Okay, 'cause otherwise, you know, we worry because we don't know where you are and we don't know if you're alright.

[S23] Two of the clients, Joyce and Graham, are very difficult to motivate. Graham will go to the park, but other than that he will only see his friend Robert once a week, whereas the rest of the time he spends in his bedroom. He will not go anywhere else.

[R14] Well, it's cooking and cleaning; it's like living a normal life.

[S21] Basically, helping people to lead their own lives. Helping people to realise what their needs are. Helping someone to gain confidence and self-respect in achieving a sort of life they want to lead.

[S18] I think perhaps the one thing I would hate would be to have a mental illness. I feel sorry for people with mental illness. I think that people have got a raw deal if they've got a mental illness. They don't get the sympathy either that, say if you've got a cancer or if you've got something physical.

The Personal to Impersonal Domain

The Personal Pole

[BL] It's easy to slip inside yourself Joyce, isn't it?

[R14] I do slip inside myself.

[BL] I do that, slip inside and I have conversations with meself and a talk with meself.

[R14] Do you...I know what you mean, you lose contact with the outside world.
[BL] I do it sometimes and I have to touch myself and say 'Whoops', you know.

[S24] God, if I start taking Joyce's blood pressure there's no stopping her getting on my nerves. The next situation that might arise then is maybe I should give her an injection. I mean I don't agree to introducing these things into the house.

[S23] They say 'I can't do that, I'm ill.' Joyce and Peter both say that. 'I can't do that, I'm ill. I'm taking medication.' I have heard this so many times before in residential, you know. It's sort of learnt behaviour that if you say you are ill to people they will say 'Oh, alright', you know.


[S20] If you've got some background in mental illness that's important. I find it a bit worrying to think that they're filtering out the trained staff as the new houses are opening up.

The Impersonal Pole

[S18] I don't have any sympathy for her. Once she'd been to the doctor and got her tablets then she said she couldn't take them and she wouldn't do that; oh no.


[S19] One of the clients who was not very well was spoon-fed. I just find that
difficult. I mean, I have spoon-fed people myself, but they just can't do it for themselves, but all the clients in our house can certainly feed themselves.

[S21] It's difficult to cope with people who have some mental health problems who might be being abusive towards you. Being personal, you know. It can be distressful sometimes having to cope with that.

The Intuitive to Analytical Domain

The Intuitive Pole

[S18] I think as well, I get the impression, just a feeling, that they want to know, you know want me to know, that they are ill and I must protect them, and they don't like being pushed on their own two feet, you know; they don't want it, really.

[S17] Being sick is a role that they're comfortable with really.

[S24] Joyce has definitely settled into coming down and have breakfast, go shopping and go back to bed for the day. It will be very difficult to get her out doing anything.

[S19] There aren't any [groundrules] as far as I'm concerned. I've got to where I've got to give the clients encouragement and support. Basically, I'm just trying to improve their lives.

The Analytical Pole

[S18] Can I say something?

[R14] Yes.

[S18] You won't take offense, will you.
[S18] But I think the problem is that if you're sitting down all day thinking about how your body's feeling, that's where you getting all your emotions from...

[R15] ...it's important...

[R14] Now I'm sensitive and I felt that life had left me...

[R15] ...you have to snap out of it; you have to accept it really.

[S23] She's convinced she's pregnant as well. And of course that upsets Joyce because she has these delusions about babies and things so that sort of sparks off a reaction in Joyce.

[S24] She says she's confused. She walks around the house saying 'I'm so confused, I don't know what's happening to me; I'm confused.' So she knows she says that she's confused.

Discovery to Didacticism Domain

The Discovery Pole

[S24] I say to her 'Joyce you should trust me' and she'd say 'Yeah'. 'Well, it's not true', I'd say, 'do you believe me' and she'd half-way say yes to things like that if she thinks you could be right. I usually ask her to come look in the mirror and she can see then that she's got an ordinary nose. I mean you know just to kind of make her face realities herself rather than just telling her.

[S23] With Graham and Peter there have been big problems with money and the handling of it. I don't know what the answer is to that.
Suddenly they got this massive Giro when they came out of hospital. It's eight times the amount of money and I don't know how you prepare people to handle it.

The Didactic Pole

[R13] You pay the rent. We have meetings. We have a meeting on a Thursday; they changed the day. When somebody comes; be about five.

[R14] The help I got at the hospital. That nurse had a chat to me about when I was schizophrenic and he taught me about talking to people and I haven't had a relapse since. It helped me chatting to people.

Process to Goal Domain

The Process Pole

[S22] With this job with clients, you have to decide what to do sometimes. So it makes you take a difficult and different stance compared to my previous job. It makes you build yourself up to actually enable you to find your confidence. You will learn whilst you are working—the attitudes and skills—and will pick up how you know how to go on with each and every one of them at very particular times—their moods and happiness and whenever they are sad. You learn personally by the patients.

[S18] You need to be a good listener, even when they are not telling you what they like, but trying to work it out.

[S17] I'd like to have peoples' pulse checked and reported once a month, and recorded as a precautionary matter.

[S24] We're not nurses!
[S17] Well no, but we can show you how to take a BP and a pulse; there's not a great skill involved.

[S23] I don't agree with that; we're not actually nurses.

[S17] When people are on medication...

[S23] We're working in a house; we're not actually nurses!

[S18] I think Graham's beginning to trust me now; he tells me more than he did in the beginning, you know, and he also works with another person quite a bit. And I think they get on very well.

The Goal Oriented Pole

[S17] A GP wouldn't give us the information and it's the psychiatrist who's actually prescribing tablets GPs should prescribe and a psychiatrist would never check peoples' BP, pulse and weight and realistically I don't think we can expect the GP to do it. If we get the community psychiatric nurse to do it then fine, but he doesn't see everybody.

[BL] If it's just that he's been unengaged for so long, what is the way forward with him?

[S23] He does play draughts. We only talked about this last week. We have actually got a game set on order. So at least when we get some more recreational things round the house hopefully we will be able to get him to do that. But even if we say, when he is going over to the pub 'I'll come over with you and we'll have a game of pool or darts', he will not do it when we get over there. I don't like to encourage him to go to the pub because
don't think it's very healthy the way he uses it. I don't think using it every day is very healthy, even though he is actually socialising when he goes out.

[S17] I think it's very important that the government be theoretically committed to a complete range of facilities being available. We don't have the daytime activities in terms of social provision and occupational provision. I would certainly want to see those available for the clients rather than isolated housing in the community, where they are turned into mini institutions because you're not able to integrate them into the community.

Support to Challenge Domain
The Support Pole

[BL] What would you say pleases you most?

[R14] Nice bedroom.

[R13] Nice bed...oh, nice to have a room; nice and clean. You can lock your room up when you want to go out.

[BL] What would be the main difference, would you say?

[R16] No nurses to tell you what to do. Got more freedom. I mean, you can go where you like, as long as you have proper time to.

[S23] Nobody has had any induction days since I started in April, and most people started after that, apart from Wentworth.

[S18] It's everything. From cleaning the toilet to counselling. The job title is
very appropriate because it's 'support worker' which is basically to support the clients through all day. It doesn't include actually going out with them to day centres, I suppose.

The Challenge Pole

[R14] I didn't do anything when I went mental. I went to work. I don't know how I went to work. It's embarrassing being a mental patient and I think that was why I was in the hospital.

[R13] I don't like seeing the hospital grounds; I don't want to go back there...fights and things.


[R16] Every time I was always in there there was a fight.

[S24] There are times when you're working 25 hours on your own. It's a bit unsupportive at times. Plus I mean you might not see a particular senior that you want to see by virtue of the fact that we do shift work.

The Moral Grid

Presentation of data is in the form of narrative exemplars displayed on the four Quadrants (Figure 11).
Figure 11. A reference sheet for the moral grid, examined in Chapter Five. The axes of the grid represent degrees of high to low expressivity (E) and high to low structured domination (SR).

<table>
<thead>
<tr>
<th>E</th>
<th>SR</th>
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<tr>
<td>HIGH</td>
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<td>There is a lack of care for the capacity of another individual for personal discovery. A person's experience is disregarded or re-framed on the experience of those in power.</td>
<td>There is an ideal of equality and mutual respect; but the scope of experience to which these ideas apply is greater than in Quadrant 3.</td>
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<tbody>
<tr>
<td>The imposition of control. Considerable restraints on the part both of those who do and those who do not have power. Confrontation is generally avoided.</td>
<td>Individuals state their interests and desires, perhaps, but alienation is is observed, in contrast to integration.</td>
</tr>
</tbody>
</table>
We also need, once people have settled down more, to start finding day-time activities so that we get this ethos that people leave the house at nine or ten o'clock in the morning and don't come back 'til five.

I think what we should be doing is to say to Penny 'If you don't behave in a reasonable manner then go to your bedroom.'

Yeah, but she won't go, see.

I think it was right to try and get Joyce out of the house.

I had to get Joyce out because she was actually starting to shout about Penny murdering her children and things.

At one point I did not answer her for two hours because she wasn't asking any questions, she was just telling me she was sick. You know, two hours; I just did not acknowledge her.

We created a bit of a problem in the house by having this happenings book that we write in day-to-day. But Penny got really dependent on that book. From two o'clock she was getting the book to start writing and waiting for the staff to come in and then when she started getting iller she started writing more about herself in the book. We started writing cutting remarks in the book to try and put her off.

It was to get a bit of reality in the book. If the book is going to be that important, let's put some reality in it.

She doesn't read it anymore does she. She never asks us about the book.
[S24] I think the residents are being picked on as an example of how successful community care can be. They are pushed into doing things they don't want to do and they are being told they have to do it. Like going to the day centre or something. And Graham for example doesn't want to go and the poor man is sitting up in the park pretending he's at the day centre.

Quadrant 2

[S24] She told the doctor she had diarrhea.

[S17] It's any excuse.

[S23] And then she had a sore mouth, cause she was compulsively washing it out and rubbing it with a towel and trying to talk at the same time; it was very difficult to understand what she was saying.

[S17] I mean like generally just after Giros arrive, let him ask--I mean particularly over the weekend let him ask--but as we're coming towards the next Giro then we can say to him, 'Well, you know, you've got a bit spare, do you want to get a couple of packs of fags today', maybe encourage him to take a little bit more out, if it's only like there's a lot of money left over towards the end of the week. Would he find it helpful, the money-box idea?

[S24] I had it for two days for him. So what I did was actually put money in the bottom of Peter's box, until there was only like a ten pound note left, so I just gave that to him.

[S19] I'm a great believer in clients not sitting on their bottoms, and this tends to be the case, although I do understand that these people are having a new experience in their lives and they are quite used to sitting down.
[S23] It's hard to keep the house up to standard and I find that I take time away from the clients, or bully or push clients to cleaning that they don't want to do.

[S24] I found it extremely frustrating; I was ashamed of myself. I was so frustrated, I felt like saying really horrible things to her. You know it's like when your baby-sitting a child when you feel like slapping it or something.

Quadrant 3

[R14] I got one bag up the stairs and Graham carried my chest of drawers up the stairs and walked up the stairs with it, didn't he Penny?

[R13] Yeah. They had a go to get all our stuff in.

[R14] I said to him, 'Oh my god, you can't come up on your own', and he got right to the top.

[S18] Is that why he's been resting ever since?

[R14] I don't know what gave him the strength.

[R13] Yeah, now I think, yeah.

[S18] He's been resting ever since, Penny.

[R13] Yeah.

[R14] I can't see normal. I don't know what I look like.

[S23] Graham's been doing some washing up lately.

[S23] Oh yeah.

[S24] I had to ask him because Joyce cooked his dinner. She's a very good cook. You know she's really good fun Joy is. She gave
us a hand on Saturday and it was no problem. And I put some vegetables in and so at least they were eating the vegetables as well. But she is getting worried about her weight; she's talking about it a lot now. But I think that might be because Penny's talking about her stomach being bloated that Penny's just got that, you know, to think about.

[S17] Has everybody been weighed? And been recorded in the files?

[S18] Graham gets tired a lot. He's self-medicating, aren't you.

[R16] Yeah.

[S18] He takes his own medication and he gets very tired. I mean I don't know if it's side effects of the medication, but he does get tired. He rests a lot during the day and doesn't really go much further than the pub opposite, do you.

[R16] No.

[BL] What would you need to make that dream come true?

[R16] Money, clothes, teeth...teeth.

[BL] What help would you need?

[S18] But you don't want teeth!

[R16] Go to the dentist.

[S18] What, are you changing your mind now about it?

[R16] I'm changing my mind.
[S20] To be in that environment with that person for 25 hours I'd be inclined to switch off and think, 'Well, okay. Enough's enough.' You need a break because you're not giving your full attention.

Quadrant 4

[R13] We just cook it yourself! You cook it yourself!

[R14] Choice in the cooking; it's nice isn't it.

[R13] It's nice to cook it yourself.

[R14] You can choose your own diet; very nice isn't it Penny.

[R13] It is freedom of choice and not the canteen...we get sausages! Didn't get many of them in the hospital.

[R14] And biscuits, nice biscuits.

[BL] This is what the camera-man was doing when the BBC film crew were here...

[R15] ...yes, was doing...it's brilliant, isn't it...

[R14] I don't know where all the weight keeps coming from.

[BL] The other thing you can do, Peter, is that you can turn the camera like that, yes, to focus on different people.

[S18] Well, Joyce, you eat for kicks, not hunger. It's the case of the donuts.

[R14] What do you mean?

[S18] Joyce, it's the case of the donuts. That's where the weight is coming from.

[R14] Well, I don't eat that many donuts.
[R15] Why would you do that with the camera?

[BL] Well, you look through the glass in the lens to check and adjust the focus this end.

[R15] How do I do that?

[BL] Just put your eye here...twist this...now everyone can see on the monitor what you're seeing...Joyce.

[S23] I just couldn't imagine people coming out of hospital, having been in there for 10, 20 years, and going to live in a house in the community and not having someone there for 24 hours a day and to take some risks with that and find that 'No, they don't need someone there at night.' I think that's really good. To say from day one, 'Well, we will see how it goes. We are not going to sleep here. If the need arises we will do so, but we will actually take that risk and see how it goes.' I think that was good.

[S22] The only thing I can think of is patience and listening to them. You don't treat them like ordinary people. You have to be calm and patient.

[S20] I think I try to inform the residents about choices and decisions they can make for themselves so that enables them to live their own individual and independent lives and it gives them back responsibility for their lives.

[S19] I think it depends on the clients sometimes. If they want to have a social life, we'll give it to them if we can.

[S23] I think there is contention between what you feel would be good for the client, and what the client wants. You might feel, 'Oh god, I've done nothing because the client doesn't want to do anything and is unmotivated
and I can't alter it.' Then there's the danger that you will push so that you are seen as being a support worker--like with Graham who attends the day centre but doesn't want to go there. He doesn't like it.

Once again, examples of the researcher's fieldnote observations are contained within the analysis chapter. An effect of interpreting the data will be to deconstruct it further, prior to reconstructing and synthesizing in the final chapter.
DATA ANALYSIS OF SHRUBLAND LANE

Although there is only one exit interview from Shrubland, triad session and house meeting data is also collected, continuing the availability of a source mixture of 'unstructured' data to process on the bipolar frame of reference and on the moral grid. The ability of a participant observer to cope with such a rich mixture of data may depend upon the consistency of immersion and of method in the study. I find that in working with this data it is the hypothesizing nature of my participation as a constructivist that strikes a compatibility in what otherwise might be a strain in depth-involvement more akin to ailment than to analysis.

A Critique of Judgement

A data collection timetable was known to participants' in the study. Or, to put it another way, people knew when I was expected at the house. The residents, staff, and I negotiated, within the collaborative
employer-university arrangement, eight hours a week in which to collect data in the third year of the study. House meetings, team meetings, and triad sessions were identified in advance. Data was collected each week from a different house, as a minimum scheduling commitment. As it happened, I was informally invited to be with people in the houses, and the schedule became more of a backdrop as a relative stranger became more familiar. This arrangement suited the self-selection aspect for participants, which originated in the pilot study around ethical issues of minimising intrusion (Chapter Four). There was a random chance of which staff and which residents might be available in any event, for various reasons. The methodological advantage of early scheduling also meant that I was in continuous 'circulation' through the heart and veins of the study.

Experiencing the varying tempo, pace, and character of the resident and staff groups in the different houses had the effect of concentrating my thoughts and actions. A dual perspective is evident. The constructivist method of enquiry is openly investigating itself, i.e. the person as research method partakes of the search. Within the triads, my questing is to open self-discovery to the conductor of
research by entering the trials of those experiencing the new house and the new life outside hospital. The openness, the non-judgemental nature, and the risk of doing something unplanned, is evident in this data chapter. The second perspective is the researcher having 'a finger on the pulse' of differing points in the body of research at-hand, i.e. in each of the houses. By treating what I hear and see as new knowledge, and having to react and respond because of being there, methodically containing and recording our evidence, silent or interruptive or otherwise, the research 'hears' people's voices and words in a constructivist manner.

The nature of the person who is conductor of the research is non-judgemental insofar as the judgement has been made that he should be open-hearted and unguarded in being with people. The experimental triad session was a precursor for the ENB 993 fieldwork. The triad was a test of the prior knowledge (synthesized in the educational framework of Chapter Five) that hypothesizing man presides 'behind' his actual presence, behind his actual words. The catalyst for self-discovery would be an approach to investigation, to learning, to development, that would give method to the process of man the personal
scientist. One is not on one's own, cancelling, or changing or altering, modifying who that other person is, to suit one's 'own book'.

Data presented in the previous presentation chapters demonstrates that the staff group and the resident groups experienced a significant, differing pace and style. Although evident in the size and content of presented data, the video-recorded tapes portray this to an extent which is not possible in a written medium. The high level and sharpness of interruptions by staff, the speed at which staff used words and the absence of time for the clarification of what was said, all represent two fields, two arenas of reality among the multiple constructions of individuals. The realities of a fast and slow field are evident in triad sessions, and in this context the fragmentation of data in deconstruction is representative of life experience.

The narrative method of presentation of data allows an examination of the assumptions of self-participation. There is staff evidence of seeing the resident as being closed by mental illness within and waiting for cracks to push light into, whereas other staff narrative presents the view that illness is a
coat covering the resident, with staff seeing the light shining out, through its cracks. A method of deconstructing data enables the investigation to examine the character of its parts.

The person-as-method, where the person is a hypothesis-tester, is central to the constructivist argument that emerges in the earlier chapters, and naturally this person includes the person conducting research. Applying this point to the current research, there is an assumption that behind the psychiatric phenomena of mental illness, there is something authentic about self-discovery, i.e. that it is 'there' to be known about but that mental illness 'provides' a fertile context in which it can be seen to be happening. A constructivist approach bends attentive ears and eyes to the opening of staff and resident voices, minds, and bodies.

An Interpretation of Data

The Shrubland data contains further evidence that what support workers do and what there is to do is of considerable concern to them. This can be represented in an analogy between what they know, as expressed by what they do, and what they hypothesize about but are
uncertain about as the result of being disconnected from an experience of knowing. For example, participants in the research refer to knowing which people need help, and to what extent they need help, with cooking, for example, and as a result of their knowing, they set out to give their support. To this knowledge they have found or experienced a sense of being connected, because they have put their theory into practice. However, arising from this is an unattained, separate knowledge which arises by anticipation of dilemmas predicted on the basis of their knowing that is connected to experience, e.g.: 

[S20] It's hard to know where to actually intervene. You don't want to impinge on their privacy, their lives, and it's hard to know where your role is.

[Because, using the convention of bracketing—in the experienced meaning of the construing observer, you are expected to ensure that people eat as you and I know is healthy, and if they do not you will be said not to be doing a proper job.] That the knowing is hard is emphasized by being repeated twice. The knowing may be impossible as connected knowing unless there is a mechanism for testing what the role is and how to intervene and what it means to impinge on privacy.
There is an undiscovered knowledge; it is there to be found, is the impression of the data, but 'you' are not personally connected to it:

[S22] I would like staff to have unity, to work as a team. I think you should do this by way of respecting people, accepting them as they are, and working together.

The interpretation of separate and connected knowing within individuals points to a need for unity, or coherence, within the person, which may be recognised as a deficit in the staff group, if, as here, it is seen to interfere with personal coherency. [I think if we worked together by respecting people we could have unity.] A difficulty this lady had with not knowing, in terms of not connecting her theory to practical experience, was 'not knowing when someone who is not in a good mood is going to hit you. You are a bit scared it's going to happen.'

The data portrays staff as self-knowing without having discovered enough to satisfy themselves. Resident opinion about living a 'normal life' refers to freedom, cooking, keeping the place tidy, paying rent. Staff refer to these points but add qualities that are absent in their experience of support for residents. Examples of the absence dimension to their knowing includes an inconsistent approach to support work,
residents lacking interest or motivation, difficulty coping with mental health problems when residents 'get personal', mutual respect amongst staff, bullying or pushing residents, and treating them like children. Unconnected knowing may then be directed at one's self, even though a personal theory remains untested:

[S18] When they have no interest and no motivation I find that very hard. I tend to take that personally.

The team leader postulates that if the support workers are empowering the residents then they will learn and develop:

[S17] It's about empowering, about increasing freedom of choice so that the clients--and the staff for that matter--know the consequences of their decisions they are making.

In the absence of an answer to the question of how to do what is referred to as empowering, unconnected knowing would appear to be disabling for the staff.

More of the participants constructs present in the 'Self Concern to Responsibility for the Care of Others' domain than in any of the other five domains in the bipolar frame of reference (Figure 12).
Figure 12. A reference sheet for the six-domain bipolar frame of reference, examined in Chapter Five.

1. Process Oriented..................Goal Oriented

2. Discovery..........................Didacticism

3. Intuitive..........................Analytical

4. Support............................Challenge

5. Personal............................Impersonal

6. Self-Concern......................Responsibility and Caring for Others
In contrast to Wentworth, the next two most populated domains are different, maintaining the point in the opening of Chapter Seven that there is regularity only in the variation of constructs.

By using a bipolar frame of reference, it is possible to confirm that knowledge may be seen to be constructed relative to the self, such that it is paradigmatic rather than conceptually fixed. That is, self-knowledge, self-discovery, may reside in a context of multiple realities, in contrast to the apparent monological, single concept, subject-centred constructs which leave disconnected-knowing people in a 'blank' of not knowing what to say or do. Taking a resident's money and locking it in a money-box while at the same time finding that unsatisfactory represents an unconstructivist view of the resident as an entitled experimenter. Finding a method for unifying separate and connecting knowing that is replicated in practice would involve residents in a questing for self-discovery in common with staff.
Ways of knowing are apparent in less of a dichotomized state and more as parts of an connecting empirical process of complete knowing. Separate knowing alone may be a viable way of proceeding, but experienced as being unsatisfactory, it may only achieve staff resignation, resident failure, or unobserved damage and disturbance. As one of the staff said, 'I take time away from the clients, or bully and push them...I don't like that part of it.' The question remains, 'How do I know how to best use my time...' [if I think that] '...people don't want to do anything.'

The moral grid (Figure 13) is a context in which the analysis of an empirical process of knowing can be pursued. However, a new light is thrown on the premise for the grid, especially analysis in the context of the notion of structured domination. For if the empirical process of knowing is incomplete, then the lack of free attention and a 'real' meeting of people may be as much the cause if not the cause of a lack of moral space. In other words, separate knowing on its own may result in domination, and in retrospect, this is a point that was germinating in the Wentworth analysis.
Figure 13. A reference sheet for the moral grid, examined in Chapter Five. The axes of the grid represent degrees of high to low expressivity (E) and high to low structured domination (SR).

<table>
<thead>
<tr>
<th>E</th>
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<td>Individuals state their interests and desires, perhaps, but alienation is observed, in contrast to integration.</td>
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</table>
Evidence of this finding, following its emergence in the bipolar frame of reference, is a comparison between Quadrant 1 and 4 of the moral grid. The moral space that is evident in the latter, by virtue of the evidence of free attention, represents at least the potential for individual linking of separate and connected knowing, if not joint questing. Here there is resolution of the 'contention between what you feel would be good for the client, and what the client wants.' There is contention, but analysis points to a resolution that includes a self-discovering process of knowing, rather than a 'separate' answer to 'how to' question.

The self is centred differently in separate and connected knowing, relative to its pervasiveness in a process of complete knowing. For example, in Quadrant 2, there is a sense of shame and horror at the thought of wishing to slap a resident, such is the tempo and deep personal not knowing of how to resolve the frustration. And in Quadrant 1, the act of simply not acknowledging a person in crisis for two hours is evidence of self-domination if not intimidation, induced by incomplete, or separate, knowing.
Self-discovery, on the understanding of the growing analysis, is becoming more a feature of a complex process of knowing than an entity with set characteristics.

Participant Observations

The fieldwork notes yield substantive contextual data, although they are also evidence of the analytical process during a constructivist approach:

The house has been open a month. Penny has been readmitted to hospital and the senior support worker has resigned. The staff said Penny had been disturbed for several days. She was smashing glasses early of a morning. They took her to the hospital and waited one and one-half hours to see a doctor.

At the September team meeting, there is some anxiety about Penny's anticipated return in two weeks. Staff have the impression that she will not be readmitted to the hospital and therefore require a psychiatric nurse to look after her in the house. If she does not return to the house in two weeks, the team leader wants to offer her place to somebody else. Two of the staff said repeatedly they are at their wit's end with Graham and Peter; it would seem from what they say that these staff spend most of their time washing clothes. It was agreed that staff would stop giving them cigarettes or loans of money.

On arriving for an 18th December, 1989, triad session, I found Graham not feeling well and his keyworker upset that he had broken his 'smoking contract' with her. The painters and decorators are busy for the second day, completing their six-month repairs. The house also seems crowded with staff, following the new project manager's
dictate that all house teams must move their base out of hospital into the houses. Penny is also unwell, curled up in a chair. Joyce and Peter seem frightened. When I asked Peter if he would hold Penny's other hand, he went away. Staff are ignoring Penny, but on the other hand I think they're frightened, too. I showed Penny how I sometimes calm myself by focussing upon my breathing, and asked the staff afterwards to note how you touch someone to comfort them and be unguarded with a person and yet supportive and connected to them in their distress.

During the December team meeting, the team leader again questioned the suitability of Penny living in the house, following her second readmission to hospital.

My January meeting with the team leader was centred upon Penny. He said her reaction to the test-dose, as he put it, of Haloperidol was that she was 'sitting in her own urine.' However, she had doubled her tenancy time in the house, following her first 'breakdown', readmission to the hospital, and return to Shrubland Lane during the summer. To revoke her tenancy would require her consent. The team's annual leave is in a mess, he says; he himself has 17 days to take before end of March.

The Shrubland interviews are complete in May 1990. Penny has been back almost four months. She seemed to me less animated but to have more resolve. She refers to readmissions with great seriousness and poise, I thought, when discussing with me how she might avoid further difficulties. For example, I know how surprised the staff were to hear from her that she has changed mind about a plan to live with her husband again. His relationship with her has been acrimonious and demanding, in my observation, and I was from the beginning uncomfortable and skeptical about this plan.
The 'deselection', as one staff member put it, of residents may be a characteristic of the chaos and disturbance arising from disparate ways of knowing. The resignations of staff, and a strong desire that their own claims should be taken seriously, is further evidence of the importance people give to self-discovery. If the emotional, or 'intuitive side', of personal life is experienced as being set aside, there is the possibility by disassociation of creating a pathology in moral life. If the personal and moral features of an individual are thought at some level within the person to be dissected out, then self-discovery through separate and connected knowing may be impossible.

A Reflective Statement

A constructivist approach is personal and moral and based upon a form of dialectical interaction. The data indicate that distant situations have moral influences. A moral grid is not for reading off universals from moral exchanges of staff and residents. However, as with the Wentworth data, a relative absence of being guided in a dialectical form may represent an absence of being cared for, an absence of being directed, and a factor in those
data references where 'domination' figures in data being placed on Quadrant 1 rather than Quadrant 4.

The analysis of two types of knowing, separate and connected within individuals, raises a question of whether it is the equilibrium between the types of knowing that catalyses self-discovery, since the disequilibrium is also evident in the data.

Participants experience the occasion of being 'out of touch' with their own experience, and the data shows that participants experience a lack of clarity. A clutter of constructions over-ride individual construing, such that individuals are unavailable to others. This may impair personal care by virtue of the disjuncture of a 'real meeting', a free-attention to the knowledge and experience of the other.

The difference between the staff and residents, in terms of pace and style alone, is evidence of the ambivalent role of language. If personal knowledge and experience is unacknowledged or distorted by the 'clutter', the capacity for self-discovery must be curtailed.
The Fielding Road house is occupied by four ladies. The residents and the staff presented a similar age profile to the other houses, with average ages of 65 and 32, respectively. The average length of in-patient time for these residents was 18 years, compared to 21 for Shrubland and 14 for Wentworth.

Data sources for Fielding, in addition to the semi-structured interviews and structured questionnaires, include three triad sessions and an exit interview.

Semi-Structured Interview

Staff Perspective

The need to be understanding and have understanding of the experience of mental illness was conveyed in the
question of 'What is most important to you in doing the job you have to do here in the house?' Extracts from the data exemplify the point:

Understanding of the effects of long-term mental health problems | Patience and understanding | Help them become aware of their own potential | Understanding residents' traumas leading to admission | Understanding mental health problems | Make yourself ready to listen to them | Make life more fulfilling | Work as friend with the residents | Inform people about what they are expected to do.

Self-descriptions of what staff do in this house contained principled statements as well as those that focus upon the 'running of the home', as the team leader puts it:

[S33] Very much like you do in your own home. You plan what you are going to eat. You buy it. You clean up after you. And then there are the social components.

[S32] That depends very much on whether there is adequate staffing and what the resident's condition is. The condition is often made worse by misunderstandings or lack of communications between staff.

[S34] If nothing else, being in hospital removes a lot of your personal skills, your communication skills, your life skills, because you have no need to use them. If people are going to live in the community again, then they must have that, otherwise they cannot go out in confidence.

[S36] I could very easily go and do lots of things for them, but what will I be achieving at the end of the day? Many of them have skills to do many things; it's just that presently, over the years, they haven't put those skills into practice. But the skills are there.
What I do is I help the residents do what they can't do. Go out with them. Draw their pensions, and after that I help them budget their money. I help them to pay their rent and then show them you know go with them and help with their confidence and see that they pay their way.

I help them to cook, keep their rooms just day-to-day living, you know, attend day centres, make appointments for doctors and dentists.

We teach the residents to cook and look after themselves and get used to knowing their way around the new environment. In the house it will be cleaning, cooking and budgeting. Be more tolerant to each other in the house with the others.

As far as the groundrules are concerned:

They seem to chop and change. I have only once experienced a meeting of the staff and at that time there was no question of staff discussing anything. We were told what we could and couldn't do.

It's not so much groundrules as routine. It's simple things, like why the afternoon is menu planning.

The months I've been here I have not been aware of any; they seem to change with the team leader.

You have to be very understanding with people and caring and able to advise them when they are sad—you have to console them; you have to be kind, really. It's what's inside you; cooking is not important, nor a degree or anything else. You have to have something in you that your nature is to be that... It really made me feel good, after Lorna and I went to Spain and came back to my home that she said, 'Thank god to be home.' I just laughed; it really made me feel good to think she trusts me that much and that my house is her house. That's how I want to work here. As a friend.
Really, what it boils down to is to allow these people their freedom to do what is reasonable. If they are happy sitting around drinking tea all day, that's alright. To them, the quality of life has improved. To me it may not. But I am not them.

Residents Perspective

One of the residents, a widowed lady, was a civil servant, and made a analogy in her past that refers to her present living circumstances:

I lived there until I was 14. They said through me being run over by a lorry when I was nine that it affected me brain; well, they thought I was dead actually. I would say now it was a pity 'cause what's the point of me living here?

She lives with two single women who had never been married and Sally, who was married but living apart from her partner. While the latter had been to school until the age of 12, Francis said she had 'no school' and Lorna said 'I don't know anything.' 'Sally can't think of anything,' Sally said and, on a separate occasion, Lorna said to the same question, about helpful life experiences in the past vis-a-vis living in the Fielding Road house, 'I can't think.'

Liz, the former civil servant, and Sally, did not view the hospital as the 'address where you lived previously'. Sally also expressed doubts about living
in the house, saying 'I don't like none of them' and Lorna, when asked what it was like living in the house said, 'I don't want to live here.' To a number of the questions, Francis, the eldest resident at 72 years of age, said 'I don't know; I just don't know what to say.'

*Structured Questionnaire* (Appendix IV)

The Fielding residents gave themselves significantly different ratings in one 'area' than other residents in the study. When asked to signify 'Easy', 'Slightly Difficult', 'Very Difficult', or 'Impossible', to shop, fix meals, and take care of financial matters, only the Fielding residents found these difficult or impossible. All four of them indicated it would be very difficult or impossible to make a complaint if merchandise was broken or if they were overcharged. Two of them worried about money every day, and two worried about the future every day.

Fielding is the only group to form a consensus in the questionnaire item that they needed help 'avoiding emotional upsets and crises'. One person was somewhat
dissatisfied and one person very dissatisfied living at Fielding Road, bringing to three the number of residents in the study who were not satisfied with where they lived.

Their collective response to the question of what they liked best and least about their present situation is as follows:

I want to get better and go home | How beautiful I am | Don't like anything best | Sometimes it's peaceful.

Cooking, I'm not sure of my bearings | Nothing least | Don't like it here, really | They make us do too much.

None of the Fielding residents knew the name of their general medical practitioner, nor did they know each others' surnames, or their postal code, or where personal records about them were kept. In the study as a whole, seven of the 13 residents knew the name of their GP, four knew the surnames of other people in their house, two knew their postal code, and two indicated that they knew where their personal records were kept. Eight people viewed themselves as patients and five not so; seven people viewed themselves as fit and healthy and six not so.
The collective Fielding response to the one most important thing learnt 'moving from hospital into the community' and the 'one piece of advice you would give to somebody who is going to move' is as follows:

They helped me in a lot of things—cooking, preparing meals. I've learned nothing. I used to like living in the hospital. I don't like living here. I don't like it as a home, that's all. It's not easy. There's too many staff.

You got to look after yourself, do what you can, enjoy yourself, and do a bit of cooking. I wouldn't move at all. Can't say what it would be. Go with a friend, somebody you know.

The Bipolar Frame of Reference

The overall pattern of referencing is distinct for each house, although Fielding alone did not present more references on the 'Self Concern to Responsibility and Caring for Others' domain (Figure 14). As with the other houses, data is presented on the bipolar frame in order of highest number of references in the six domains.

Discovery to Didacticism

The Discovery Pole

[S31] You need to be a good listener. Even when they are not telling you what they like, but trying to work it out...It's difficult to know which direction to go, over protective or not enough protection. Each individual is
Figure 14. A reference sheet for the six-domain bipolar frame of reference, examined in Chapter Five.

1. Process Oriented.................Goal Oriented

2. Discovery.........................Didacticism

3. Intuitive.........................Analytical

4. Support..............................Challenge

5. Personal..............................Impersonal

6. Self-Concern.....................Responsibility and Caring for Others
different. So some might need more attention, but some might not, so some might suffer and some might not.

[S34] In this particular house it is definitely based on bringing back to life skills the residents have had in the past that have not been lost in hospital. And then consequently having to develop them further.

[S32] Some weeks, when there is adequate staffing and the residents have not been upset, you can take them to the pictures, or take them on picnics and explore ways in which they would like to change their lives.

[S30] I think if there's some way of how we can understand how it feels to move out of hospital for somebody who has been institutionalised so that we can understand the feelings that person is going to have about moving out.

The Didactic Pole

[R26] That's all I want to know is that, ah, I'm more upset to think that I'm never gonna go home.

[S29] I think personally that your key worker is going to look into it and find actually what the situation is over there for you.

[R26] Is she... what's happening with my flat.

[S31] You're not sure how far they've actually developed, so that you need to go with them. How do you know unless somebody actually tells you?

[S29] If we are talking about structuring a client, the key worker would plan with the client the activities, and when they were to be done. Then all the staff would be involved in carrying them out.
[R26] How to get things sorted out with my money. I've got plenty of money but I can't get hold of it. It's all in the bank. I've got to get signatures.

[BL] How many signatures do you need?

[R26] I don't know, but I want to find out. I would have liked to have got things sorted out before I moved in here. All my bits and pieces, my jewelry, everything!

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Personal to Impersonal Domain

The Personal Pole

[S29] I never really enjoyed it from day one. I am a structured person. That is one of the reasons I have to give up the job, because I cannot cope with shift work because my home structures go up the wall.

[R25] Having Sally [R25] back again; that's the most important thing.

[S35] You have to love people. You have to have a belief in God as well. And you have to like working.

[R26] Yeah, but we talk--we...

[S31] ...we don't--none of you lot really talk to each other; you don't sit down and have a conversation. I'm not criticizing any of you; but you do not do it.

[R27] It is all the same.

[R26] Pardon?

[S31] You don't do it, none of you. It's just... there's four of you in now--forget Sally because she's not here most of the time--but you three are here all day.
[R26] Yes, I know that, dear.

[S31] You don't talk! You don't talk!

[R26] Well I talk to Ann [S30] and Lorna [R27], but--well, what can we talk about?

[S31] That's what I'm saying! If you found an interest to do during the day right, if you went out and Lorna went out to a day centre, Francis went out somewhere, then you could all come back together and say what you'd done during the day. But none of you have told us what you want to do so you can't talk.

[R26] Oh.

[S32] The attitude of the staff is greatly different... other members of staff have totally different ideas anyway, and so do people higher up. So one wonders if there is any real direction from them anyway.

The Impersonal Pole

[S29] Even though staff are fully aware that mental illness does knock motivation off, we all get annoyed at times when they will just not do anything and we tend to ascribe it to laziness sheer and simply. It's a can't-be-bothered attitude.

[S31] I help them to cook, keep their rooms tidy, just day-to-day living, you know.

Support to Challenge Domain

The Support Pole

[BL] Is that the telephone?

[R25] Yes. It is the telephone. Yes.

[BL] Who should answer it?

[R28] The staff always answer it.
So what will you do because there's no staff here, just let it ring?

Yes.

Well, I um...better go and see... shall I answer?

Do you think so?

Yes.

I spoke to one of the members of staff a few weeks ago about what was happening in the team--most of which I thought was bad, to be honest--and he said, 'Yes, I agree, but I have not been able to say it because I am not an articulate kind of person.' So he found it helpful because he had found someone else verbalising what he felt. I think we came up with something constructive. This is what we need to be doing. We should be working towards this ideal rather than staying where we are.

Consistency of approach, I think, is especially relevant. With the client group we're working with, good communications is terribly important.

The Challenge Pole

There is absolutely no supervision whatsoever for the staff, so that when staff are having difficulty with a situation there is nowhere for them to go to say, 'How do I handle this person when she's having one of her agitated days or confused days.'

You could never describe the job because you don't expect to come to work to cook, to clean and make beds unless you are actually employed as a nurse in a hospital. You're in a house. You don't expect to have to do that.

Well, that food today! Them hamburgers! If you say anything to staff, they say, 'Well, it's your dinner, dear.' What can you do about it? It should be more decent.
New staff should not be given so much key working straight away. It's a stupid idea to chuck a client at someone and say, 'Here you are. Key work this person.'

Process to Goal Domain

The Process Pole

Some people will be very firm and shout and scream at him and others will have a different approach. You can't lay down the approach because it will not work for all staff. Some staff are much better at standing off and giving orders and because they are firm it gets done. Others cannot do that and are much better and perhaps helping a lot more.

The client group is under the effects of years and years of institutions. This means a lack of conditioning and motivation. They can so easily be considered as lazy and lethargic, but in a lot of cases it just is not so. It's very important to appreciate what the clients we are working with are experiencing.

I think we need to use all personal experience of workers and past experience and knowledge to teach the residents. By knowing the residents, their likes and dislikes and habits, then you know what the weak point is of each resident and you can help build up their confidence.

Did you hit Lorna with the trolley? Don't get angry. Just stay calm and we'll talk about it.

No, I moved a trolley that got in the way of anybody, you just push it aside. You don't hit 'em with it, do ya! And you think I'm that kind of a woman, then?!

She says that she didn't.
[R27] Uh, I'm waiting for my money to come through...

[R26] ...Now, there ya are, she's talking about waiting for her money to come through, then she's saying I hit her with a trolley.

[R27] You did hit me.

[R26] I never!

[S31] I don't know I wasn't there...

[R26] ...No, I'm not that kind of a person to hit people with a trolley...

[S31] So, what other things have been happening, Lorna?

The Goal Oriented Pole

[S36] I look forward to coming to do my share of work every day, so should they. I think there could be nothing worse than to wake up knowing there is sod-all to do all day.

[S29] For me, it's leading a normal life and having a practical task-oriented way of going about things that leads to orderly and patterned ways of living...For the clients, it's a case of reinforcing. 'What's today? It's Tuesday?' And go to the chart. 'This is Tuesday. What we do on Tuesday is this, this, and this.'

[S33] You do have to have a structure. When I started it seemed to be that intervention was wrong somehow. Intervention was seen as failing; I think that's so far from the truth, you know. There is a need for a lot of positive intervention. A lot of the time.
Self-Concern to Responsibility for the Care of Others

The Self-Concern Pole

[R27] I don't want to live here.

[S36] I'll need something constructive to keep me going. But for them, because they have been in hospital for a fairly long period of time and without any sense of responsibility, they have become so much accustomed to life as being where you have everything there and so there is no need to do anything if you have everything provided.

Responsibility for the Care of Others

[S33] All these people push for community care and that people who are new to it I don't think always appreciate the actual clients don't see this as progress. If you have had everything done for you, so then expect people to plan, shop, cook, clean, and so on. That's not improvement to them. It's bloody five steps backwards. So a lot of it is you're fighting.

[S31] Doing the right thing. Making sure that you are doing the right thing, not just for yourself but for them as well.

[S29] I have a very strong commitment to being with clients and socialising with them. If I am doing a domestic task and someone starts talking, then I will stop and I will talk, even if I have a lot of tasks planned for that day.

Intuitive to Analytical Domain

The Intuitive Pole

[S33] It's terribly difficult to clarify it all. It's just a feeling you get and pick up as you go along, really, isn't it.
[R26] He [R1] don't want to know us! Does he. I mean it's alright to talk to him and that but he just sits there and I think he misses his daughter and wife and that. I mean I always speak to him on the phone if I can, and if we go down to the local to have a shandy, but he can't stand Sally--I mean her going up to men and that, you know, and asking.

[S29] Your relationship is something you use to get the tasks done. It's your method of approach, which is different for everyone. We've got the best motives but we've not got the best approach. We're still trying to do the best we can for clients but we don't quite know the right way to do that.

The Analytical Pole

[S29] If we discussed as a team we would get a wider variety of opinion and hopefully reach some sort of consensus so that the whole team will then approach problems in the same way because they can see the logic of the approach that has been decided upon. That gives the client more confidence because they are being handled in a similar way, especially with cigarettes and things. Uniformity of approach is essential when someone is trying to cadge cigarettes.

[S33] If I were the client and I saw all these staff trying to encourage me to do everything, then I'd like, 'They're being paid. Maybe if they tell me to do it.' Something's wrong here, somewhere. This relationship is actually so difficult to develop in a lot of ways. It's terribly hard to keep saying, 'We will be terribly, terribly...', and so on, and sort of share. You've got to say, 'I've swept the floor so now you've got to mop it.'

[S36] I can't find myself sitting down idle all day. But maybe that person is happy doing it this way. Although it would be my
responsibility to inform them of the values of doing something constructive. The benefits and rewards derived from that are self-satisfaction.

All this will be put to them. But at the end of the day it will be their choice.

Moral Grid

As with the other houses, data will be presented quadrant-by-quadrant (Figure 15), to amplify the ebb-and-flow of knowing and experiencing between people in the study.

Quadrant 1

[S34] God only knows how the residents were selected, because in this house, and in Wentworth, there are severe personality clashes. People who should never have been living together, who, if they were in society, would never have chosen to live together.

[S33] People are not trained or experienced and are expected virtually on their own to go to somebody who is actually acutely ill. I just don’t like being a part of this—subjecting people who work for you to conditions like that.

[S31] Well, if you were a patient you'd be in hospital. You're not in hospital, are you. You left hospital five-six weeks ago. It's not as though you've been back, stayed there or anything.

[R26] Oh, I see.
Figure 15. A reference sheet for the moral grid, examined in Chapter Five. The axes of the grid represent degrees of high to low expressivity (E) and high to low structured domination (SR).

<table>
<thead>
<tr>
<th>E</th>
<th>SR</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a lack of care for the capacity of another individual for personal discovery. A person's experience is disregarded or re-framed on the experience of those in power.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is an ideal of equality and mutual respect; but the scope of experience to which these ideas apply is greater than in Quadrant 3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The imposition of control. Considerable restraints on the part both of those who do and those who do not have power. Confrontation is generally avoided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals state their interests and desires, perhaps, but alienation is is observed, in contrast to integration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOW</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
[S31] So, you're not a patient, are you. So, is that cleared up?

[R26] Yes.

[S31] You're not a patient. So, what would you want to do? Have you got any plans?

[R26] No, I've not got much plans.

Quadrant 2

[S29] It's very challenging to work with clients and I don't think that it's the sort of client that a new staff member should be given to key work because it is incredibly demoralising and tiring when they are talking non-stop or something. There's a bit of damage done there.

[S34] It feels very much like it's a 'fall down, try again' thing rather than being constructive and structured. It's very much, 'Oh, well, it didn't work. We'll try something else' but without a big knowledge base to pull from.

[S30] I think it's very unfair that trained nurses are going, because we were employed as support workers and then supposing anything regarding mental illness--a patient relapses, anything unusual--it reflects back to us.

Quadrant 3

[S29] If staff were aware that mental illness does affect motivation they would be less harsh on the patients.

[R26] Everything seems to be dirty to me. I don't mind living here, but I've got to get settled, haven't I. I don't want to put the wrong things down. I like living here, right. If I've got to live here that means that all my home's gone. I've worked hard all my life. That money in the bank is mine, you know, they would ask, 'Mrs. Beales? You've still got
plenty of money in there.' But they don't do that here. I would like to get better. I hope I'm doing the right thing. I'm getting a bit settled.

[S34] I can't even find any information about what the residents skills bases are. You're working blind, really.

[S33] We actually all know these people like the back of our hands. If their needs can't be identified after all these years, then God help them.

[S32] Not being able to sit down and talk about things with other members of the staff. One at a time it is possible but it does not actually resolve any problems because most of the problems seem to be caused through lack of communication between staff.

Quadrant 4

[R28] Sally talks to any of them.

[BL] Do you two talk together sometimes?

[R28] No.

[R25] No we don't. No. She says about making the tea half past two.

[BL] You [R28] say, 'Sally are you going to make the tea?, something like that?

[R28] No.

[R25] Ah, Francis don't; she makes the tea sometimes.

[R28] She makes tea.

[BL] Sally does.

[R28] Yes.
[BL] Have you become close friends, now you've lived together for some months?

[R28] Oh, she's become a close friend.

[R25] We have become close friends, yes.

[S29] Try to avoid judging clients before you've met them and have got to know them. Take them as individuals. Take them as human beings, normal people as far as you can. Give them credit for more than may appear on the surface initially. You cannot gloss them all with mental illness and assume they are all going to be the same. A lot of them have more knowledge and more skill than would appear.

[S32] To help residents develop in a secure environment. To be there, to help them overcome anxieties. To help them become aware of their own potential and that of the community in which they are living.

[S35] We are close. We are friends. It's a job, yes, but as a friend. Friendship job, that's how I take it...this is not just work. You are dealing with sick people, and you are on your own with sick people, so you have got to have some kindness.

Six people in the study provide ten hours of 'unstructured' video-recorded data, while the triads, house meetings, and team meetings amount to 50 hours. Thirty people gave responses to the semi-structured interviews, each with 13 items, i.e. 390 responses. The residents gave 105 responses each in the structured questionnaires, resulting in 1,365 data items.
Data for presentation represents individuals' personal views, or theories. Data selection is a function of a constructivist approach to self-discovery and, therefore, much of the 'structured' data did not emerge in presentation. However, that evaluative data is available to the supported housing project.
The residents and staff make clear statements to the researcher about their lack of satisfaction and difficulty in knowing what is right. The researcher as a part of investigative methodology is part and parcel of an empirical struggle that is repeated within individuals. The repetition of a will to know in each house represents a use of personal research that is shared by the researcher and the investigated people.

A Critique of Judgement

The researcher believes in the value of narrative, as being integral to educational research and practice in the science of human service, referring to the community mental health service. A biographical example is the reflective study of hospital and community 'baselines' in Chapter Two, with its focus upon the self-discovery of himself and Mr. Mann. Although constraints in the deconstruction of data are
noted elsewhere, the use of the researcher as a source of narrative data with other participants opens the research to critical examination, rather than closing the data to personal discovery by an examiner.

Data is drawn from the initial, the middle, and the end stages of the one year study. The bipolar frame of reference and the moral grid have been used to apply a constructivist approach to analysis, using prior knowledge and current data to interface in the research methodology. An enlargement of the data has developed as analysis progresses to focus upon the thesis subject. An anomaly of the constructivist approach has been a blurring of the whole 'picture' while the focus of its parts is expanded. The researcher's decision to amplify the data, in a study of a constructivist approach to self-discovery, may result in the data being seen only to portray positions of disadvantage and advantage. Such a construing of the data would not, in the researcher's judgement, be evidence of a constructivist approach to the data. Constructivism recognizes dichotomous thinking but takes it 'one step further' by proposing that hypothetical thinking be given a mechanism for theory testing and experimentation.
The residents and the staff of Fielding Road are frank about their dissatisfaction with life and work in the house. From the residents perspective, this is reflected in their responses to the structured questionnaire, where they are asked to specify their level of satisfaction, by ticking an appropriate box. By contrast, when asked an unstructured, i.e. an open-ended, question they have been as speechless, 'struck dumb', or as 'blank' as residents of other houses. From Lorna's 'I don't know anything', to Sally's 'Sally can't think of anything', to Francis' 'I don't know, I just don't know what to say', there is a disconnection between thinking and responding, as is indicated in the structured questionnaire responses, and discovering how to apply their thinking in practice.

The staff present as knowing but not knowing how. They theorise that their job is about making 'yourself ready to listen to them', making 'life more fulfilling', working with the residents as a 'friend'. However, the 'conditions' for achieving this are ruined by 'misunderstandings or lack of communication' with each other and 'the totally different ideas' of
each other as individuals and 'the totally different ideas of the higher ups'. Yet, the Fielding staff, and the staff from other houses, are searching for a way to use 'what's inside you'.

There is a strength of 'voice' from the data about the need to know, the will to know, and a wish for knowing, expressed by a Fielding worker in the dilemma, 'You need to listen but even so it's difficult to know which direction to go...' [Using the convention of bracketing the informed observer's interpretation, this is experienced as meaning, in the context of the other staff evidence, 'Even if you can listen and really hear what the message from the resident actually is, how do you get from that point to deciding what you actually do in response? Is it to act to protect the resident by telling them to do something that you know will be safe, or is it to leave them to their own devices because you want them to learn how to do something but at the risk of them failing and hurting themselves and maybe demonstrating you are a failed support worker? But even before the decision about which way to go, how to get there and be in a position to know, rather than being stymied by all the prospects of what might happen?']
Fielding Road house continues to contain a will to know with a disparate sense of knowing and not knowing, both in the abstract and in the practical. Two types of personal knowing have been identified: separate knowing and connected knowing. Being 'blank' associates with separate knowing and where a gap exists between separate and connected knowing. A constructivist approach to self-discovery associates with connected knowing.

The staff data formulates an 'answer' to a significant expression of wanting to see how to proceed, given the numerous dilemmas that require an answer from within people as individuals. There is a collective example, within the 'Discovery to Didacticism' domain of the bipolar frame of reference (Figure 16): staff need to know how to 'go with them' in the residents questing, their 'sorting out', 'bringing back to life' what's been lost in hospital', doing it with them while they are 'trying to work it out', doing it by 'understanding the feelings that person is going to have about moving out' and exploring with them 'ways in which they would like to change their lives'.
Figure 16. A reference sheet for the six-domain bipolar frame of reference, examined in Chapter Five.

1. Process Oriented......................Goal Oriented

2. Discovery..............................Didacticism

3. Intuitive.................................Analytical

4. Support.................................Challenge

5. Personal.................................Impersonal

6. Self-Concern.........................Responsibility and Caring for Others
Upon this interpretation, the relevance of self-discovery would lie in the connections that individuals might make between their separate, hypothetical, and their connected, experiential knowing. The character of self-discovery appears in the data as an incomplete empirical process of knowing. For example in the 'Support to Challenge' domain of the bipolar frame of reference, Sally's 'Shall I answer?' is the 'start-from-scratch' of a quest for knowing that emanates from within. The moral question that is the converse of self-discovery lies in the deprivation of reality, that bind in which people are willing themselves to know but denied the personal support resources and the individual know-how.

On the 'Process to Goal' and 'Intuitive to Analytical' domains there is an identification of what the formulation for self-discovery might be: 'Some people shout and scream...others cannot do that and are much better and perhaps helping a lot more.' | 'Your relationship is your method of approach.' | 'It's essential to know the personal experience of each person and their knowledge and apply that to the residents knowledge and experience.'
Having to work blind, or to live without seeing how to fill the 'blank', is a condition that impedes or obscures the cure that is envisioned in Quadrant 4 of the moral grid (Figure 17).

By processing data on the bipolar frame of reference and on quadrants of the moral grid, a struggle for self-discovery presents as a method of enquiry, a need for the how-to, in anticipation of an act of knowing. Within a person using this method, a culture to mediate separate and connected knowing is being nurtured, e.g. in Quadrant 4. Whereas, in Quadrant 1, what is acknowledged to be 'inside you' is inert: 'I've not got much plans' is a legacy of the 'fall down, try again' regime of separate knowing.

Participant Observations

The field notes offer perspective into the network of intra-actions and inter-actions in the investigation of a constructivist approach to self-discovery.

The house has been open for one month. Two of the staff I've been with are trying to do everything for the residents, herding them about the house in a group, from one domestic task to the next. The sheer pace of their thought, talk, action seems to me blinding in the face of the residents thinking, speaking, and doing. There are no living room tables, so we had tea on the floor. One of the staff is demanding to know from Lorna why she said
Figure 17. A reference sheet for the moral grid, examined in Chapter Five. The axes of the grid represent degrees of high to low expressivity (E) and high to low structured domination (SR).

<table>
<thead>
<tr>
<th>E</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>There is a lack of care for the capacity of another individual for personal discovery. A person's experience is disregarded or re-framed on the experience of those in power.</td>
<td>There is an ideal of equality and mutual respect; but the scope of experience to which these ideas apply is greater than in Quadrant 3.</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>The imposition of control. Considerable restraints on the part both of those who do and those who do not have power. Confrontation is generally avoided.</td>
<td>Individuals state their interests and desires, perhaps, but alienation is is observed, in contrast to integration.</td>
</tr>
<tr>
<td>LOW</td>
<td></td>
</tr>
</tbody>
</table>

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she'd prefer to be in hospital.
Liz asked me why she hadn't got her dentures, five months after moving from the hospital. The staff explained to us that the hospital dentist had kept her dentures rather than make a mould and give her back those teeth to use. I knew from Wentworth's experience with two residents that, after a long-wait, they had been dissatisfied with uncomfortable and ill-fitting dentures. The support workers said they would explore the possibility of a community dental service.

November, the nights are drawing in, and it looks odd that there are no curtains or lamp shades in the kitchen or dining room windows. One of the staff helped me dig out two shades and a roller blind that had been purchased and we installed those. The ladies who live here continue to walk about with their hand bags strung over their arms, regardless of what they are doing in the house, e.g. washing dishes, cooking, hoovering, or other assigned jobs that the staff have set them to do. When I enquired if they could not lock their valuables in their rooms, the support workers were not clear whether all the tenants had keys. It became apparent that the staff had no keys and that the residents were locking themselves in their rooms at night and Francis in the afternoon, as well. The staff wanted duplicate keys.

There is an accounts-type ledger book in the sitting room. The date on its cover is 29-10-89. I see the staff are using it to enter shopping and other expenses that are day-to-day household expenses and food. Also on the coffee table in the sitting room has appeared a book containing staff requests for special duty arrangements. Two of the staff asked me to help them with their frustration and annoyance when Lorna 'pestered' them for her money, which is kept by staff, although she has a daily amount which I notice is tucked beneath her blouse, because she takes it out regularly to check. The staff said she started having 'paddies', which is their word for temper tantrums, following the decision that she had to save ten pounds a week. This seems to have followed quickly on the heels of the moneybox practice at Shrubland Lane.
March, 1990. Lorna burst into the staff meeting and objected to her door being 'locked all day.' Staff said it was because of smoking. Then Liz came in and said 'My rights are being taken away because of smoking.' Lorna is now receiving two pounds a day from staff, 'due to her buying too much cosmetics and toiletries.'

Given the pilot year and the main study year, a deepening immersion by the researcher may be expected from preparation for protracted participation in the intimate life experiences of the residents and staff. There is a measure of difference between the observations, interpretation of the data, and the bracketed meaning of the researcher's experience with staff and residents. These different hermeneutic styles within the study afford the researcher a chance to experience a symmetry during personal research and to be its biographer. The video-recordings served to create mental space for construing amid critical dilemmas, as a method of self-assessment regarding his method of questing and of investigation. Making regular observations of his self, in the presence of participants and alone during transcription, provided a systematic safeguard from escaping the reality of his own intuitive reacting in the face of dilemmas and circumstances, which made a live and shared community of the research.
A Reflective Statement

There is an evident primacy in the need for self-discovery. The evidence of separate and connected knowing points to a unifying mechanism that will create the 'space' for the research participants to fill blanks and answer their questions. The questing for a reality that they 'know' inside of themselves is countered by dilemmas arising when they are deprived of testing for that reality in social experience. The relative absence of supervision, for example, is a denial of the prospects in supervision for self-discovery.

The demand for supervision in this data is substantial. Therein, lies a potential for the self-discovery of a personal resolution to the troubling, disassociated, fixation between procedural knowledge and conceptual knowledge that 'skips-over' self-knowing.

That the research data portrays the view of knowledge as being procedural and conceptual is a challenge to a constructivist approach to knowledge that identifies alternative, multiple realities that are personal and among persons.
The data show that procedural and conceptual knowledge are not enough to satisfy the needs of participants; they are peripheral decentred realities compared to the self.
The final chapter is an opportunity to examine how the research can be used. For a constructivist ending, the reader will be referred to parts of the thesis which demonstrate or explain the approach to self-discovery. The investigative process of inquiry is interpretative and determinative. That is, of the many aspects of knowledge, a constructivist approach is a self-selecting mechanism for determining what they might be and what testing needs to be done if solutions are to be found.

An Overview of the Research

Elaborating Outwards from a Central Focus

A constructivist approach to inquiry has used a naturally-occurring modus operandi of the research and practice double-helix, of knowledge and experience, that was documented in Chapter Two. Constructivism emerges in a field of research and practice where 'subjects' are often denied their heterogeneity
(Chamberlin, 1979; Harding, Zubin and Strauss, 1987; Oliver, 1991). 'Putting patients first' (Dept. of Health, 1989) can be viewed as an attempt to redress the denial by administration. Without a methodology, without the practical 'how to do it', there may be little prospect of achieving the vision of community mental health care (Secretaries of State for Health, Social Security, Wales, and Scotland, 1989). By taking an educationalist's perspective, with a focus on self-discovery, a constructivist approach has attempted to methodologically centre the knowledge of the investigated people. Therefore, the focus upon residents and their circumstances is a centre-point for data reconstruction.

However, the research indicates that 'Putting Patients First' may be a false vision. From an investigation in a human service that is about mental health care, a constructivist approach to self-discovery finds that knowledge is invariably de-centred, away from the person who is meant to be first. Guidelines which conclude this chapter may be helpful in formulating further practice and research that use a constructivist approach to address this issue.
Harry [R1] from Wentworth Street was outspoken as the house opened, regarding his discovery of the threat that he experienced from John and Marie. In retrospect, the expulsion of the couple from the house may have been averted had the staff been in touch with the extent of knowledge about them. The credence in my theory stems from working with Harry during the piloting stage of research. Although it would be inappropriate to draw upon data from the pilot, it is worth noting that my observations in the main study stem, in this instance, from my work with Harry. We tested what was eventually to become the structure for triad sessions, by video-taped recording of he and I as keyworker and client. My work with Harry left me connected to what he knew, which was based upon his knowledge and experience of John and Marie in hospital.

Peter's [R15] money became a difficult issue for the staff, as soon as Shrubland Lane opened. While staff hypothesized that Joyce and Penny were, in effect, testing their personal limitations and using the 'sick role', both Peter and Graham were having their money put into a locked box. Although Peter seemed to agree
to the idea, at the same time he was accusing staff of stealing money and belongings from his room, and Graham received personal loans from staff to 'tide him over.' The money-box idea became a reality when staff discovered that Peter was giving some of his money to strangers, although staff surmised that he and Graham spent too much money on cigarettes and beer.

The residents at Fielding Road also occupy the centre in data reconstruction, insofar as their staff found that despite wishing to understand and 'Make yourself ready to listen to them', separate knowing became predictive and generalized, e.g. 'None of you lot really talk to each other', as if the residents represented what might be expected in hospital but not in the community, even though residents had not known community living, on the basis of 'first-hand' experience, for a number of years.

The research evolved from a cross-disciplinary examination, reported in the early chapters of the thesis. The investigative process of finding a constructivist approach in a pluralist tradition of research, had a harsh impact upon the evolving heuristic design. While a constructivist approach to investigation has been achieved, an effect of this
process has precluded an in-depth examination of personal constructivism, of personal constructs and construing. The nature of practicing mental health care, e.g. the cameo of Mr. Mann in Chapter Two, raises the spectre of human science as a personal science, especially when matched against the impersonal nature of traditional research and institutional care. However, the guidelines section that concludes this research will attempt to map a route through the current research that may inform attempts at in-depth personal research in the light of this study.

Data from the Literature Review

The Literature Review constructs the subject by examining and synthesizing prior knowledge. This data can now be reconstructed in a configuration with the following aspects that are in relation to one another: the researcher, the other participants, and data gathered. Any fieldwork encounter, from a constructivist view, involves a shifting interplay of personal and social interaction, anxiety and defence (Hunt, 1989), in the process of data collection.
Prior knowledge from the literature, preparatory to primary research, is obtainable as empirical, objective evidence. However blind to that process, participants are known by the researcher. The stranger became well-known to those participants he had not worked with over the years, at the hospital, as the result of a prolonged piloting stage and the extent of immersion in the life and work of the houses.

However, in the case of Peter, Graham, the ladies at Fielding Road, and other participants, the extent of critical analysis of the literature establishes a context in which their evidence can be reconstructed.

The literature in question extends to Chapters Three, Four, and Five. Philosophy, ethics, and methodology are linked in a cross-disciplinary review. The centrality of thematic issues are illustrated by and located in the three curricula by-products of the research (Nightingale and Guy's College of Nursing, 1989, 1990):

a) The first principle being, from the in-service Transition Training course, that people develop and
grow despite their disablements, in a context of accomplishment towards a desirable future;

b) Providing a method of being with people that is educational, by being with them in a way that validates their personal knowledge and experience, is the second principle which was instrumental in the curriculum design of the ENB Course 812 course for community psychiatric nurses;

c) The empowerment principle of participatory research and the acknowledgement of multiple realities that is inherent in personal construct theory accommodate self-discovery, even for people with mental illness, who participate in the ENB 993 course in residential and day care.

These aspects of sociology, psychology, and education, are substantiated in philosophical constructivism, as is elaborated in Chapter Three. Indeed, Lund (1991) argues that psychotherapeutic practice is a form of applied philosophy.
The multiple realities (i) of multi-disciplinary interest in mental health, (ii) of institutional care, and (iii) of community residential support are linked, in a constructivist approach, by the thematic issues of:

a) valuing people nevermind how different they are and believing in their potential for valued experience in life;

b) anticipating an educational method in which such an open investment in the personal life of other people is a learning model;

c) providing a context in which collaborative inquiry to test personal theories arising from such an experimental approach might be tested.

The configuration of data from the first two years of the Ph.D. process is illustrated by the researcher's application of the literature research to curriculum development. The testing-out of empirical data, as it were, within this Ph.D. collaborative programme, demonstrates the double-helix of research and educational practice methodically at work in the investigation of a constructivist approach to self-discovery.
The research method (Chapter Five) reflects the testing-out process of the action research aspect of the collaborative arrangement during the early years in the study. Therefore, the rules for Harry's construing about John and Marie at the Wentworth Road house were neither supplied or elicited. Nor is a constructivist approach to investigation intended to be one of intervention in any other way. Since much of the data collection was unstructured and the researcher a participant in the video-recorded proceedings, his internalisation of the constructivist approach repudiated his wish to 'head-off' the crisis of John and Marie's expulsion from the house. His theory was that the staff wished it, partly because of their absence in the selection of John and Marie to live in the house. Therefore, as the data was constructed over a number of months, Harry emerged as a tentative, quiet voice of dissent about household management habits, to a friendly then demanding critic of staff, regarding the cause-effect relationships of John and Marie vis-a-vis the quality of life in the house.

The dynamic between a constructivist approach and Peter's apparent consent to money-box management is also evident in a configuration of the whole of the
study's data. During a triad session, Peter takes a personal interest in the video-recording and learns how to operate and to focus it, and himself, on a subject. In this instance, a constructivist approach is constraining a researcher to rely upon naturally-occuring events, i.e. Peter's self-inquiry about the equipment and its process, to 'loosen' a confrontation between Joyce and a member of staff, who is acrimonious and belittling of Joyce's language items. The personal opening-effect of the methodology is the same for the member of staff and Joyce, as for Peter and the researcher. Peter discovered that he himself would test his theory that staff were, in effect, stealing from him.

An example of multiple-realities in the research context coming together to catalyze self-discovery in a constructivist inquiry is the series of 'paddies' at Fielding Road. One particular shouting incident in the data involved a staff paddy, during which three of the residents were accused of not talking to each other and not actually being 'in tune' with what was on the television. A constructivist approach had the effect for the researcher of reiterating his private construing, constraining his professional interest, and concentrating his participation upon the
analogies that might be blocking self-discovery in individuals and in the group. One of the residents objected to her hypothesis and contradicted it. People learned for themselves in the paddies, because critical moments of self-discovery were created when the field of personal and interpersonal construing became public experiments in testing rival theories.

A Personal Reflection on the Overall Findings

With professional knowledge as its instigator, the transition from hospital to community life occurs. Such a transformation of personal and social life for service users impinges upon research methodology in two ways. First are the ethical considerations. In particular, a constructive approach to investigation expresses a need to balance the striving of the staff to grow and develop in a mental health service that is trying to conserve the dignity of its work, against the questing of the people who use the service for self-dignity, self-expression, and self-discovery. Second are the educational considerations. The kind
of knowledge that is useful in such a transformation is constructed from a cross-disciplinary investigation that includes the 'popular' knowledge of people who use services.

The epistemological and methodological aspects of personal and social transformation in mental health care are integrated, and can be experienced by service providers and service users, by concentrating upon the way in which knowledge is generated. A constructivist approach to an investigation of self-discovery has explored a method of inquiry, derived from an educational perspective upon psychotherapeutic care.

If it were considered important to think about the practical management of knowledge, its acquisition and application, as it is in education, the relevance of this research will be in its usefulness across a multi-disciplinary community for a coherent, shared approach to human and service development. As a mechanism for determining what is known, the application of constructivist method is compatible with multi-disciplinary working, where a single disciplinary approach, e.g. a psychiatric method of hypothesis-testing, may be inconsistent with the day-in-day-out experimenting of support workers.
The extent of personal, social, and cultural construing has demonstrated how research participants can be blind to each other and/or to what the researcher is doing. Regardless of actual reality (this research indicates there may be no such entity), in a mental health care context, a person transfers onto another person constructs that belong to their own conscious, unconscious, social, or cultural knowledge and experience. Interpreted 'literally' by staff, for example, the reaction is likely to be a rebuke of a resident, rather than acceptance, in the knowledge of research findings, that there is a presence of meaning behind the words and/or actions that would, without intention, deny the percipient's equally self-centred view.

The intersubjective construction of narrative can be explored by muting the dichotomy between researcher and 'subject'. Through deconstructing the narrative, an understanding can be developed of the intersubjective process of fieldwork and data construction.

Through an experiment with the development of curricula as the research progressed, it was apparent that the sociological empowerment model, of individual
and service accomplishment through valuing devalued people, lacks a mechanism for social integration. Used in in-service training without a constructivist centre, of personal knowledge and experience (service users were not present), the result within the course and after the transition from hospital, within the research, was a pattern of confrontation between staff and residents.

The data substantiates in the bipolar frame of reference and the moral grid that analogous thinking occurs as individuals act to test and integrate personal theories in anticipation of their hypothesis that arises from individual construing. Human science is thus seen to be focussed upon self-discovery; will to knowledge is catalyzed by the mechanism of construing.

In a constructivist approach to an investigation of self-discovery in mental health care, there is always something authentic behind the sealed mouth of residents apparently not knowing and behind the mask of an engendered mental illness phenomena. Seen through constructivist research, heterogeneous qualities in people are subject to homogeneous forces in a world aggressive with Cartesian Anxiety.
Constructivist findings are oriented toward reaching and understanding, elaborating outwards from a reconstructive analysis. The research approach anticipated new experience, overcoming anxiety by learning to live without the 'infinite intellect' of finality and absolute knowledge. Based upon a paradigm rather than a monological concept or self-serving method, learning as evolved from a constructive approach is linked to the acquisition of self-discovery rather than new techniques.

A Researcher's View of the Integral Relationships

The effect of a constructivist approach upon a teacher's thinking is indicated in the data analysis, by showing that the 'blank' in peoples' minds is a useful mental space, given a method for personal inquiry. The same missing link, an approach that catalyzes self-discovery, is absent from the empowerment model of training and from the participatory research model, where the proposition is one of the teacher joining the students in a shared collaboration toward gaining knowledge.
Disassociation and disempowerment are effects of linking the empowerment and research theories and applying them in an investigation of a constructivist approach to self-discovery. However, the disassociation from his role and the change in his teaching method, i.e. to investigating by reaching 'within' rather than transmitting to the students, immersed him into the life experience of learners who are residents and staff. On reflection of his experience using a constructivist approach in both the classroom and the houses, the clarity of the research in 'hearing' and 'seeing' the evidence and the development of the teacher-researcher are enhanced. The video-taped recordings and the three curricular by-products of the research are a permanent record of the extent to which the application of a constructivist approach is integral to the research and to self-discovery.

Development of practice in mental health care, whether in education, research, or management, may recognise differing levels of construing in the research and the dichotomous nature of those constructions. Construing can be pre-conscious, conscious, sub-conscious, interpersonal or intersubjective. These constructs can create moral dilemmas, e.g. 'We told them it was
for life', referring to the expulsion of John and Marie from Wentworth. Although a construct is an abstraction, attributed to several events which are set apart by other construing, it is possible for individuals to lose control of events, and of themselves, if they do not have a method for construing, for creating a mental space in which self-analysis and critical thinking can be practical tools of their being with people. This is important for staff and resident retention in the supported housing project.

Used for guidance in community mental health care, a constructivist approach to investigation of self-discovery demonstrates a difference between separate knowing and connected knowing, the latter opening up the interior of individuals to the opportunity for self-learning, rather than producing, in the absence of such opportunity, a personal sense of inferiority and distrust, sown by the seeds of an ever thicker web of relations to the self. By using a constructivist approach as a psychotherapeutic method of being with people that is educative, individual meanings can be evaluated and validated. The context of this method is the self-understanding of the people involved. The mechanism is a self-formative process,
where self-reflection reconstructs from its own
genesis a sense of certainty of the person, through
successive and continuous stages of elaborating
without being repudiated.

In educational and psychotherapeutic terms, the use of
a constructivist approach involves an enlargement of
the experiential frame of the person, a shift of
identification to the person using the service, and a
deeper self-acceptance by participants in the
process.

Although there is an unsuccessful example in the data
of staff 'packaging' descriptions of the core
disturbance of Penny at Shrubland Lane, accurate
descriptions of clinical disturbance, as well as
practical measures in response to them, would enable
support workers to cope constructively with the
challenge of mental illness without making people
worse, if not handing back control to residents who
are instrumentally affected. It may be that individual
service users will have to take the initiative on this
score, rather than wait to be enfolded in what Healy
(1990) describes as the 'therapeutic embrace of the
caring professions: an embrace that until now has been
more of a bear hug' (p. 218).
Educators, teachers, and trainers in mental health care can help staff and residents develop self-discovery if they emphasise connection over separation, understanding and acceptance over assessment, and collaboration over debate. These differences stand out as practical guidelines in a constructivist approach to self-discovery. If they accord respect to and allow time for knowledge that emerges from firsthand experience, instead of imposing their own expectations or those of the service or even more arbitrary requirements, they encourage self-discovery.

Conclusion of the Data Analysis

For the purpose of a thesis, data analysis is restricted to providing guidelines for people working in the field, where a constructivist approach to care might be used. What constructivist meaning does the data contain? Does the data define or demonstrate constructivism? Is a use for it indicated?

Questions, the need for questions, and the anxiety raised in the absence of questions, provide the basis of an answer for those in the previous paragraph.
For example in the Quadrant 4 data of Chapter Six:

[S9] It's quite complicated really when you come face to face with a person who you don't know very well...Would I do the same as another staff member?...Whatever way I did it, it would be different from the way you did it...maybe I wouldn't feel I could.

Here, a support worker is trying to think through the question, in a team meeting, about why residents in Wentworth are being neglected, in particular John -- referred to in the team leader's interview as a 'tramp' figure in the neighbourhood. The posing of a question in an attempt to construct an explanation is an example of constructivism that can be matched with its presentation in the literature chapters (Chapter Three, for instance) about constructivism in the philosophical sense.

From the Shrubland Road data in Chapter Eight, there is an example of the other side of the coin:

[S18] At one point I did not answer her for two hours because she wasn't asking any questions, she was just telling me she was sick...I just did not acknowledge her.

How does this support worker discover how to acknowledge Penny, when, in retrospect, an informed and consistent acknowledgement may have prevented her re-admission to hospital. Accompanying this data in
Quadrant 1 is a colleague's disclosure about Penny using the staff 'happenings' book to try and communicate with them and staff 'writing cutting remarks in the book to try and put her off' [S24].

The immediate response was:

[S18] It was to get a bit of reality in the book. If the book is going to be that important, let's put some reality in it.

The need to put personal theories to the test, to treat questions as hypothetical and conduct experiments, is evident, in constructing what reality is. The outcome in this case was:

[S23] She doesn't read it anymore does she? She never asks us about the book.

Acting upon the outcome, to revise the theory, would be important if a constructivist approach was to be used. As it is, in both these examples, the elaboration of personal theories continued as if the test-part of the cycle had not happened.

An example from the personal pole of the 'Personal to Impersonal' domain of the Fielding Road data (Chapter Ten) demonstrates the build-up of frustration and
anxiety from the not-knowing, as the result of not having a method to discover, to understand, the 'why':

[S31] ...none of you lot really talk to each other; you don't sit down and have a conversation...You don't do it, none of you...

The alternative to knowing is the impersonal effect of institutional care, which prompted the study as the move to community care started. It is arguable whether the effects of institutionalisation result from the nature of institutions, neglectful care, or other variables, i.e. professional interventions over time. However, it would seem that a more focussed approach based upon the science of the person would produce a significant, satisfying, preventive force in care. The alternative is obviously not satisfying:

[S33] People are not trained or experienced and are expected virtually on their own to go to somebody who is actually acutely ill. I just don't like being a part of this--subjecting people who work for you to conditions like that.

[S29] There's a bit of damage done there.

The data in this study hypothesizes some personal criteria for knowing, for construing:

[S35] You have to love people.

[S31] You need to be a good listener.
[S33] It's very important to appreciate what the clients we are working with are experiencing.

[S34] People who should never have been living together, who, if they were in society, would never have chosen to live together... you're working blind...It feels very much like it's a a 'fall down, try again' thing rather than being constructive and structured.

[S32] ...most of the problems seem to be caused through lack of communication between staff.

The quality of care for people in a mental health service, whose own self-discoveries are difficult construings to live and work with, requires an individual approach to personal knowledge that believes it, tests it, and allows multiple realities to exist without neglect.

Guidelines for Practitioners and Others

From the outset of this study in 1987, the intention has been to conduct research that is relevant and useful. The collaborative support between the University of Surrey and the health authority has ensured that the research was applied to educational practice, as it progressed, e.g. curriculum development and teaching.
The investigation of a constructivist approach to self-discovery 'took effect' as the hospital environment changed to community living and working, for the people who are in staff-supported houses. Therefore, the thesis concludes with recommendations in the form of guidelines for people who are practitioners, teachers, managers, service users, researchers, and others with an interest in community mental health care.

An investigation of a constructivist approach is defined by its early findings. Chapter One demonstrates that professionals stick to the research criteria that they were trained to use, despite changes in the research setting, i.e. from hospital to community care, and despite being told to engage in multi-professional and inter-agency collaboration. A conclusion is that training methods, apart from being in the professional interest, are linked to the practice credibility of professionals. Therefore, it is unrealistic to prescribe multi-professional working without an alternative framework or unifying approach to investigation which does not threaten professional practice or jeopardise professional research.
The early chapters of the thesis also show that professional methods, in addition to making practice legitimate, create a hierarchy of credibility with lower and non-professional groups, including service users, at the bottom. The data presentation chapters illustrate the struggle in lower groups with incomplete information. It is not surprising that their constructs seem partial, marginal, and distorted. What may be surprising is the powerful strength of wishing to discover how to overcome the obstacles to being a partial, marginal, and distorted contributor to life.

If residents are regarded as ignorant of the professionals' knowledge and if this is related to the view that they also suffer serious mental or character disabilities, the knowledge of the residents is understandably regarded as of little value and as illegitimate. There are signs of this throughout the thesis. However, in the data presentation chapters, practitioners seem genuinely and intuitively to be searching for answers to questions, in contrast to their role as research subject in the professional data reviewed in Chapters One, Three, and Four.
A constructivist analysis would predict that conflict is created in practice settings by using instruments from the top of various professionals' credibility standing or changing the philosophy with each change of managers. Changes instituted by successive managers of supported houses in this study are a consistent source of anger amongst staff. The support workers' greatest worry has been not knowing how to control their frustration with residents.

Staff complain about 25-hour shifts and lack of support, most notably of supervision, but also of varying directions from designated leaders. Team leaders thought they were not properly supervised and also complained that there was no point toward which they could direct their energies.

A crisis in the mental health care practice environment is, therefore, recognised. There are three guidelines from an investigation of a
constructivist approach to self-discovery. As a single statement, a recommendation would read:

The need to have knowledge and make solutions for problems is an opportunity to unite the centre with the periphery in mental health care. By valuing the knowledge and experience of people who use the service and of people who deliver it, a mechanism is established for generating knowledge. A culture for inquiry that accesses personal knowledge also provides a unifying basis for professional knowledge.

The recommendation restates the emphasis for connection over separation, understanding and acceptance over assessment, and collaboration over debate.

The need to have knowledge and make solutions for problems is an opportunity to unite the centre with the periphery in mental health care.

The difficulties that staff and residents experience within this research is an illustration of an often obscure, inconsistent, and unstable relationship between the hierarchy of credibility in mental health care and the people on the periphery of an organisation, where the service is actually delivered.
An investigation of a constructivist approach points to the use of the hierarchy as a resource for solutions, rather than the source of knowledge and the agency for solutions.

In this approach, part of the caring business is a philosophy of cultivating knowledge for use in sustaining personal health, for promoting the practice of giving support, and for connecting the centre and periphery as a research basis for managing a mental health service. Theories about what knowledge is relevant are generated from a practice centre to a resource centre. The diffusion of research from a centre of hierarchal expertise into practice can be accomplished by linking the service user and their key workers with a knowledge generating mechanism in the constructivist approach to inquiry.

By valuing the knowledge and experience of people who use the service and of people who deliver it, a mechanism is established for generating knowledge.

A second guideline generated is, therefore, using a constructivist approach to improve the conditions and the environment for people who live and work in
residential care. The basis of the method lies in deciding to value and facilitate inquisitiveness, inquiry, the inventiveness—the personal gifts which distinguish people as individuals. Conventional interests of a hierarchy, e.g. staffing arrangements, care planning, work loads, and time, are imbedded in a constructivist approach with a lively and real interest in individual people and their welfare.

A culture for inquiry that accesses personal knowledge also provides a unifying basis for professional knowledge.

Thirdly, if different disciplines use various methods of training and different criteria for their research, and if these methods and criteria are linked to and substantiate their practice, there is good cause for individuals to have problems coming together in multi-professional work.

The credibility, such as it is, of residents and support workers is challenged by strangers with strange ways, and by the variation of demands made by changes, e.g. of team leaders and project managers. In the face of being challenged by distant or impersonal demands, e.g. not to make mistakes or to
work to a better standard of care, the demanding people and the residents and support workers are left not knowing, confused, and anxious. A constructivist approach can be used to replicate how people can work together. The approach is illustrated in the early chapters of this thesis (Chapters Three, Four, and Five, about philosophy, ethics, and methods, may be of particular interest).

The practical constructivist way, or method, of being with a person, when that person's knowledge and experience is valued, is exemplified in Chapter Two and by some exemplars on Quadrant 4, in the data presentation (Chapters Six, Eight, and Ten). What is notable about a constructivist method of being with a person, be they student, client, colleague -- not simply by trying to 'stand in their shoes' to see through another 'window on the world', but a regenerative being together that is expressive of a desirable future. There is a belief or valuing of the person being cared for, such that one acquires the impression that there is a philosophy or vision for a person.
The 'answer' to insistent or posed questions in the data, e.g. in the first instance, not knowing or being blank but having a will to know, or, in the case of staff, 'How do I do that?', lies undiscovered within the separate and connected knowing of people who provide a mental health service and people who use it. The guidelines emphasize connected knowing, coupled with understanding, based upon the research findings, and collaboration that includes the people who are meant to be 'first' -- the people whose mental health is a source of concern and the people who are closest to them.

Specific guidance about a constructivist method is contained in the descriptions of the three curricular by-products of this research (Chapter Five). Principle guidelines about constructivist practice that emerge from the disciplines in mental health care are of valuing peoples' knowledge, of empowerment, of accomplishment, and of recognising personal constructs as valid theories that need to be tested in reality (Chapters One, Three, and Four).

A constructivist approach has been accessed by a focus upon self-discovery. From the guidelines, a mechanism of self-discovery may be raised as a form of practical
theorising, structured by practical examples of personal experience rather than sets of theoretical propositions. This hypothesis from an investigation of constructivist methodology finds self-discovery as a personal critique, or reflexivity, of tacitly acquired or 'held' knowledge, which is developed through personal, or action, research in response to an experienced problem of realising the self. Thus, as an endpoint, the research refers itself back to its centrepoint, the person construing.
Prior to writing this epilogue I gave a talk, at a church hall in the village where I live, about mental health care in the community. A fellow in the front row said, "I feel guilty when you talk about finding that people who care sometimes shout at people they care for. How does your research show how we can stop it and care like we know we want to?" The experience of conducting constructivist research, within the realities of working and living, demonstrates that investigation and investigators are connected to everyday life, which is alive with personal issues, the effects of which permeate the research setting.

Indeed, a researcher's life in the community and how he invests himself in the lives of other people has implications for the future pattern of investigation in community care. A constructivist way of attending to people by being immersed in their lived experience,
struggling to find the personal and moral space to think and act, is a precursor for further study in psychotherapeutic teaching and practice.

A will to knowledge and self-discovery confirms a place in science for the individual person, if his evidence is valued and there is a method of accounting for his contribution. The investigation of a constructivist approach to self-discovery is an example of how such an accounting can be made.

In research that has blended multi-national and multi-disciplinary experience with evidence from a new residential community service, there appears a need for clarity about how values are determined and how people find their own personal decisions, amid being troubled and out of touch with reality.

A constructivist approach is a deterministic method that differentiates between competence as demonstrated by adherence to a particular form of intervention and competence in appropriate personal involvement by
people who care. It is an enabling paradigm for investigation, because it promotes health and contains a mechanism for developing personal vision.

It has been my experience that the research is an empowering agency for individual development. A constructivist approach is a seedbed for the generation, testing and regeneration of theories. My experience of the research is one of personal transformation from a parochial focus upon my psychiatric training to an anticipation of human science that liberates knowledge from within to enhance community living.
APPENDIX I

CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

(Presented orally for discussion)

In this paper I am asking for your permission to take part in a study about your involvement in the new staff supported houses. Your participation is voluntary, so even if you sign this paper you can change your mind later about taking-part. Although we've already discussed informally as a group about my being in the houses, you aren't expected to take part unless you want to.

The study will focus on the personal knowledge and experience of the first group of people to move from psychiatric hospital into staff supported houses in the local community. Further understanding of how we discover for ourselves about living and working in the community may help other people like us. My interest is in how we learn for ourselves in new situations, like moving from hospital to houses in the community.
APPENDIX I

The main method of collecting information is by video-taped recordings of what we do. Although we may have assessed doing this by practicing with the video equipment, you are free to not participate when we're filming. If you do participate, this signed paper is an indication that we are in agreement about what is involved in the research. More structured ways of collecting information will be the interviews, which, like house and team meetings, will also be video-recorded. For people who live in the house there will be two questionnaires by interview with myself and for staff there will be one. They are strictly confidential for the purposes of this research.

You will always be asked if you wish to take part, so that we can avoid any undue intrusion to your right to privacy. You do not need to make any excuse or give any reason for not wishing to participate. I will be responsible for keeping the information you give under lock and key. When the research is written up, in 1991, your name will not be associated with the information you give, so that your identity and your contribution to the research will remain confidential.
If you decide not to take part could you tick 'Yes' or 'No' to indicate whether you mind my being in the house to work with others.

Yes ________________  No ________________

Signed ________________________________

Date ________________________________
APPENDIX II

VIDEO-RECORDING PROTOCOLS

The video-recording procedure is taken from the experience of Heilveil (1983) and Jenkins (1987). This three-page appendix consists of an outline of assessment for participation in video-recording, an observation protocol for the assessment, and interview protocol for the assessment.

1. Review the consent agreement as a first step in seeking permission to proceed. Explain and discuss the reason for using videotape in connection with the purpose of research.

2. Introduce the features of video-recording, for making a permanent record of the research and for making available a continuous assessment resource. Explain and discuss the desensitising process of creating a video-feedback without recording.

3. Place the video camera directly behind the monitor, aimed at a chair, to create a mirror, or video-feedback loop:

   a) Build up a hierarchy on the screen;
   b) First, an unrecorded image of a silent person on the screen -- the researcher and then the person(s) to be filmed;
   c) Second, repeat this process using words and gestures -- explaining and answering questions about different components of the video camera.

4. Seek permission for a second round of the desensitising process, using the film to make a live sequence to review:

   a) Tape-record the researcher -- review the sequence;
   b) Tape-record the participant -- review;
   c) Tape-record any other participant -- review.

5. Reassess permission if the participant(s) positively respond to their observation and self-assessment during the procedure.
APPENDIX II

OBSERVATION PROTOCOL FOR VIDEO-TAPED SELF-ASSESSMENT

1. Is a relaxing ambience being created, to counter the natural anxiety of the encounter with one's self-image?

2. Is there any behavioural or verbal indication that consent to participate in the video-recording has been/is being withdrawn?

3. Does the participant know the purpose of the video-recording?

4. Is there evidence that the participant understands the video-recording procedure?

5. Is the hierarchy of anxiety-provoking images on the video-recording monitor countered by a relaxing and supportive ambience, where there is an attempt at authentic and warm expression?

6. Is there evidence that the participant will be able to make and use self-object discriminations? Is there any evidence, before or during the preparation to use the video-recording procedure, that the participant would be unable to determine that the image on the video monitor is their own image? If so, s/he would be excluded from participation.

7. Are the participant responses indicating that the natural anxiety of the encounter with one's self-image is acceptable? Is there any evidence of severe depression, before or during the preparation to use the video-recording, which would exclude the person?

8. During live recording, do participants highlight positive, adaptative aspects of their behaviour?

9. Is there any indication that the entertainment aspect usually associated with television make this exercise unsuitable for the participant?

10. During self-assessment of the video-recording, what theme, or issue, or behaviour, is commented upon, without prompting? If there is any doubt in observation, what meaning do participants say is attached to their response to the assessment?

11. What do participants indicate or say, without prompting, is the significance, to them, of their description of events or moments in the video-recording?
APPENDIX II

INTERVIEW PROTOCOL FOR SELF-ASSESSMENT OF RECORDINGS

1. The first type of question deals with the first issues being observed, for example:

   a) Do you remember when I explained what the research was about and asked for your permission to take-part? I also talked about using this video-recording equipment; do you recall the purpose of using the video?

   b) Do you still feel comfortable going-ahead and getting familiar with the video-recording process?

2. The second type of question deals with the densensitising process, for example:

   a) Do you see how, as I move the camera around, the furniture directly in front of the lens is shown on the monitor? Would you like to try and get that No Smoking sign onto the monitor by pointing the camera at it and focussing by twisting the lens right here?

   b) Can you see how my image is on the monitor and yet we're not recording? Why don't you focus-in on me and I'll tell you when I think the picture is too close for comfort? Would you be comfortable joining me to see yourself on the screen? Is the picture too close for comfort?

   c) Shall we record me explaining more about what we're doing and then play it back? What would you like to ask me about my assessment of myself on video-recorded tape? Would you feel comfortable being with me and recording ourselves talking about this for a minute?
APPENDIX III

SEMI-STRUCTURED INTERVIEW PRESENTED ORALLY

(Prefaced by Reassessing Consent)

Part I. Personal Profile

1. Your name

2. Your educational/professional qualifications/date

3. Your practical qualifications: what you've done in your life experiences that may be particularly helpful for the job that you do now in this house

Or, (in the case of people living in the houses), your practical qualifications: what you've done in your life experiences that may be particularly helpful to you now you've moved into this house

4. Your current job title

Or, your current address

5. Your previous job

Or, what was the address where you lived before moving into this house

6. Your age

7. What's most important to you in doing the job you have to do here in the house?

Or, what's most important to you living here in the house?
APPENDIX III

Part II. Your Personal Views about Life in the House

8. Describe in your own words what work you do here in the house.

Or, describe in your own words what it's like living here in the house.

9. In your experience, what are the ground rules for working in the house? What are the commonplace, hard and fast rules? (If you didn't do these things you wouldn't be seen to be doing the job.) What are the basic rules for doing the job?

Or, in your experience, what are the ground rules for living in the house? What are the commonplace, hard and fast rules? (If you didn't do these things you wouldn't be able to live in the house.) What are the basic rules for living in the house?

10. What is different now, compared to your previous job?

Or, what is different now, compared to living in the hospital?

11. What is most difficult for you in your current job?

Or, what is most difficult for you about living here in the house?
12. A two-part question: First, is there anything you should have known about before you came to work in this house—that would have helped you once you arrived? Second, what should you have been able to do (in terms of skills) before you came to work in this house—that would have helped you once you arrived? Any skills that you think might have better equipped you prior to starting this job?

Or, A two-part question: First, is there anything you should have known about before you came to live in this house—that would have helped you once you arrived? Second, what should you have been able to do (in terms of skills) before you came to live in this house—that would have helped you once you arrived? Any skills that you think might have better equipped you for living here that you might have got before moving in?

13. What would you change to improve the situation here in the house now? If life was better tomorrow, what would have changed?
APPENDIX IV

Indicate what services you have used during the last six months

<table>
<thead>
<tr>
<th>Service</th>
<th>YES</th>
<th>NO</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Assessment of your personal and social needs</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b. Helping clients to meet basic needs (e.g. for food, clothing, shelter, assistance in applying for benefits).</td>
<td></td>
<td></td>
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<tr>
<td>c. Medical Care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d. Dental Care</td>
<td></td>
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</tr>
<tr>
<td>In-patient Hospital Care:</td>
<td></td>
<td></td>
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<tr>
<td>e. Hospitalisation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>f. Use of &quot;Out-patient&quot; Services - group therapy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>g. &quot;Out-patient&quot; - individual therapy</td>
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<tr>
<td>h. &quot;Out-patient&quot; - family therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Medication monitoring/administering medicines</td>
<td></td>
<td></td>
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<tr>
<td>k. Social Worker assistance</td>
<td></td>
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<tr>
<td>l. Twenty-four-hour crisis assistance</td>
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</tbody>
</table>

STRUCTURED QUESTIONNAIRE
(PRESENTED ORALLY)
(PREFACED BY REVIEW OF APPENDIX I)
# APPENDIX IV

## Indicate what services you have used during the last six months (Cont'd)

<table>
<thead>
<tr>
<th>Service</th>
<th>YES</th>
<th>NO</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>m. Training in community living skills (eg medication use, diet, personal hygiene, shopping, use of transportation)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>n. Social skills development and/or use of leisure time</td>
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<tr>
<td>o. Assistance with employment (e.g., vocational training, sheltered workshop opportunities)</td>
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<tr>
<td>p. Provide rehabilitative and supportive housing options</td>
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<tr>
<td>q. Back-up support to families, friends, or employers.</td>
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<tr>
<td>r. Use of grievance proceedings making a complaint</td>
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</tr>
</tbody>
</table>
APPENDIX IV

Indicate the extent to which you had problems with these Community Living Skills during the past month.

<table>
<thead>
<tr>
<th>Community Living Skill</th>
<th>No Problem</th>
<th>Mild Problem</th>
<th>Moderate Problem</th>
<th>Serious Problem</th>
<th>Does Not Apply</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making Use of available transportation on familiar routes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Going Shopping</td>
<td></td>
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<tr>
<td>Performing household chores</td>
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<td></td>
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<tr>
<td>Prepare/obtain own meals</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Maintain adequate diet</td>
<td></td>
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<tr>
<td>Use available transportation on unfamiliar routes</td>
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<tr>
<td>Manage available money</td>
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<tr>
<td>Ask for necessary help when you need it</td>
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</tr>
</tbody>
</table>
Indicate the extent to which you had problems with these Personal Care Skills during the past month.

<table>
<thead>
<tr>
<th>Personal Care</th>
<th>No Problem</th>
<th>Mild Problem</th>
<th>Moderate Problem</th>
<th>Serious Problem</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence</td>
<td></td>
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<tr>
<td>Walking/getting around</td>
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<tr>
<td>Dress Self</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Maintain personal hygiene</td>
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</tbody>
</table>
If you were sick, or moving, or having any other kind of problem, how much help and support would you get from (a/b/c/d)? Would it be a lot, some, a little, or none?

<table>
<thead>
<tr>
<th></th>
<th>A LOT</th>
<th>SOME</th>
<th>A LITTLE</th>
<th>NONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. your family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. your friends</td>
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<tr>
<td>c. other people in the community besides your family and friends</td>
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<tr>
<td>d. A member of staff who works with you</td>
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</tbody>
</table>

Is it easy, slightly difficult, very difficult, or impossible for you to:

<table>
<thead>
<tr>
<th></th>
<th>EASY</th>
<th>SLIGHTLY DIFFICULT</th>
<th>VERY DIFFICULT</th>
<th>IMPOSSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. shop for food, clothes, and other things you need?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. fix your own meals?</td>
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<tr>
<td>c. pay bills and take care of other financial matters?</td>
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<tr>
<td>d. complain to the shop or salesperson when you receive broken merchandise or poor service, or when you are overcharged?</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
Is it easy, slightly difficult, very difficult, or impossible for you to:

<table>
<thead>
<tr>
<th></th>
<th>EASY</th>
<th>SLIGHTLY DIFFICULT</th>
<th>VERY DIFFICULT</th>
<th>IMPOSSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. tell a family member that he or she is treating you unfairly?</td>
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<tr>
<td>f. tell a friend that he or she is treating you unfairly?</td>
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<tr>
<td>g. join a conversation at a party or other gathering?</td>
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</tr>
<tr>
<td>h. make important decisions?</td>
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</tr>
</tbody>
</table>
For each activity, a. through to m, do you "......" (e.g. "eat breakfast" etc) every day, many times a week, a few times a week, or almost never?

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>EVERY DAY</th>
<th>MANY TIMES A WEEK</th>
<th>A FEW TIMES</th>
<th>ALMOST NEVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. eat breakfast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. eat lunch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. eat supper</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. shower or bathe</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>e. brush your teeth</td>
<td></td>
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<tr>
<td>f. have clean clothes to wear</td>
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<tr>
<td>g. go out for recreation</td>
<td></td>
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<tr>
<td>h. read books, magazines or newspapers for pleasure</td>
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<td></td>
</tr>
<tr>
<td>i. watch television</td>
<td></td>
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<tr>
<td>j. listen to the radio</td>
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<tr>
<td>k. worry about the place where you are living</td>
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<tr>
<td>l. worry about money</td>
<td></td>
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<td></td>
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<tr>
<td>m. worry about your future</td>
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</tr>
</tbody>
</table>
APPENDIX IV

IN GENERAL, HOW SATISFIED ARE YOU WITH THE HELP YOU RECEIVE WHEN YOU ARE REALLY HAVING PROBLEMS OR ARE IN A CRISIS? WOULD YOU SAY THAT YOU ARE:

a. [ ] VERY SATISFIED
b. [ ] SOMEWHAT SATISFIED
c. [ ] NEITHER SATISFIED NOR DISSATISFIED
d. [ ] SOMEWHAT DISSATISFIED
e. [ ] VERY DISSATISFIED
f. [ ] Don't know

NOW, ABOUT YOUR LIVING SITUATION,

HOW SATISFIED ARE YOU WITH WHERE YOU ARE LIVING RIGHT NOW. WOULD YOU SAY THAT YOU ARE:

a. [ ] VERY SATISFIED
b. [ ] SOMEWHAT SATISFIED
c. [ ] NEITHER SATISFIED NOR DISSATISFIED
d. [ ] SOMEWHAT DISSATISFIED
e. [ ] VERY DISSATISFIED
f. [ ] Don't know
APPENDIX IV

WHAT IS THE ONE THING YOU LIKE BEST ABOUT YOUR PRESENT SITUATION?
(Record answer here)

WHAT IS THE ONE THING YOU LIKE LEAST ABOUT YOUR PRESENT LIVING SITUATION?
(Record answer here)
APPENDIX IV

For each of the four scales below, the words on each end of the 1-to-10 scale describe opposite feelings. Circle any number along the scale which seems closest to how you have generally felt DURING THE PAST MONTH.

How concerned or worried about your HEALTH have you been during the past month?

1 2 3 4 5 6 7 8 9 10
Not concerned at all

How RELAXED or TENSE have you been during the past month?

1 2 3 4 5 6 7 8 9 10
Very relaxed

How much ENERGY, ZIP, VITALITY have you felt during the past month?

1 2 3 4 5 6 7 8 9 10
No energy at all, listless

Very energetic, dynamic

How DEPRESSED or CHEERFUL have you been during the past month?

1 2 3 4 5 6 7 8 9 10
Very depressed

Very cheerful
<table>
<thead>
<tr>
<th>Task</th>
<th>No Help</th>
<th>Some Help</th>
<th>A lot of Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Budgeting money</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Shopping</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>c. Keeping the house clean</td>
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<td></td>
<td></td>
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<tr>
<td>d. Cooking</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>e. Laundry</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>f. Making friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Getting along with people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Managing medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Avoiding emotional upsets and crises</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Anything else?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Specify)______________________________
A few personal questions.

What is your date of birth? ____________________________

Where were you born? ____________________________

Are you: (tick appropriate box)

- Single - never married
- Married - living with spouse
- Married - but living apart
- Living with a partner
- Divorced
- Widowed

Are you: (tick appropriate box)

- Male
- Female
How long were you inside a psychiatric hospital?  

(total amount of time in years and/or months)

How many admissions to hospital did you have in that time?  

(number of times going into hospital)
APPENDIX IV

Do you know the name of your GP?  

Do you know the surnames of all the people who live in your house?  

Do you know your postal code?  

Do you know how to vote?  

Do you see yourself as a patient?  

Do you know where personal records about you are kept?  

Do you consider yourself to be fit and healthy?  

Do you know more people now than you did when living in the hospital?
What is the one thing you have learnt about your experience of moving from hospital into the community?

(Record answer here) ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

What is the one piece of advice you would give to somebody who is going to move from hospital into the community?

(Record answer here) ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
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ADDENDUM TO CHAPTER FIVE METHODOLOGY

A Reference to the Replication of Research

(Supplementary to Pages 163-166)

Effective replication depends upon careful analysis and understanding of the aims and methods of the study to be replicated. The original research design incorporates the use of curriculum development. With this in mind, part one of this addendum describes how the curricula are integral to the study. Part two of the addendum is a critique on data processing.

Constructivism is not a single theory but represents a united view of a personalised world, from across academic and practice disciplines. The cross-disciplinary investigation set out to understand human development in relation to a person's life-situation, and to view existence not as a set of separate phenomena, but as an interconnected whole. The research design provides a
framework to prepare for and conduct research. In the terminology of Schon (1987), and Thomas and Harri-Augstein (1985), if you wanted to find out how people learn, what people think, and why they act, look at what they do and investigate their personal views.

The three training courses (pp. 165-166) that, in-turn, incorporate the study of an approach to self-discovery, provide an 'action research effect' (Figure 1, p. 156) in the investigation. The Ph.D. study has proven to be a unique process of ever-widening connections which involve the expansion of one's intellectual compass. However, it is the process of research that is clarified here, in the interest of allowing repetition of it as closely as possible.

The early chapters of the thesis provide a corpus of prior knowledge upon which connections are made across the disciplines. These disciplines range from the emancipatory approach of educationalists (e.g. Shor and Freire, 1987) to personal construct theorists in the field of mental health care (e.g. Dunnett, 1988).
Three aspects of curriculum development that are integral to this study are described here.

The Use of Research Findings in Course Validation

i) The construction of curricula involves the progressive use of research findings in course validation. The work of three multi-professional curriculum planning teams, during the first two years of research, examined and used the literary research in the context of course validation. By using educational means in this way, the research is able to explore and develop an alternative conception to institutionalisation. The educational purpose in finding an alternative was to examine whether mental health service change, i.e. transition to living in the community, could be matched in a learning context. Knowledge of self, self-esteem, and self-discovery for staff and residents have an investigative purpose in the new context that they lacked in the institutional context (Chapter Two).

The Interaction of Research and Curriculum Development

ii) The interaction of research and curriculum development is formed by using them in a dialectical relationship, such that what is observed is constantly
modifying theory, and the result provides a fresh, multi-disciplinary schemata for the interpretation of data. A theoretical position was worked out in each of the courses, each advancing the dialectical relationship between 'theory' and 'fact' as the preliminary investigation progressed. In the third year, the accumulated effect of testing the literature research, in curriculum development, was operationalised in the main study.

Reflection of the Research Process in Curriculum Approach

iii) The researcher sought and received training to assimilate a constructivist approach to data processing, as the preliminary research found its effect in curriculum development. An emerging personal construct approach to the individual member of staff and individual service user was reversing an institutional experience (Chapter Two) of learning and enquiry. Transition Training, the ENB 812 course, and ENB 993 (Nightingale and Guy's College of Nursing, 1989, 1990), progressively inculcated the approach that theory should be derived by inviting participants to research that teased out the
personal theories embedded within that theory. The researcher conducted the inquiry with the discipline he acquired during curriculum development.

To conclude the first section of this addendum, there are two points to be made. First, the courses themselves have built into them a process for continuous development. This is based on the testing of theory in practice, in line with the philosophical underpinning of the research process, as described in the thesis. The second point is that during the process of research, on-going developments in the courses contributed to understandings derived in the research. These two interactions between research into practice and practice based on research form another illustration of the action research spiral (see Chapters Two and Five).
A Critique on Data Processing

(Supplementary to Page 180)

This research raises a question about epistemological validity in a heterogeneous cohort, in contrast to the homogeneous character of studies in the Literature Review. Since the research explores a personal approach to learning and developing, therefore the data is processed in such a way as to preserve its individuality.

The emphasis was upon collecting rich data. However, such data is complex and voluminous in nature (Pope and Denicolo, 1986). The method of data collection is largely that of the video-taped recordings, the structured questionnaires, and the semi-structured interviews. The problem of handling a vast amount of data had to be managed in a way that was as natural and fluent as its collection. The video-recorded data forms the bulk of the data, compared to the data yielded by the interview and questionnaire instruments.

The presented selection of video-recorded data, collected over twelve months, from 36 people, is representative of the approach to inquiry. Working with such unstructured material, from individual and group settings, the data
was not, in this research, atomized, transferred to cards and stored as numbers in a computer. The main apparatus for data-processing would be the human mind, attending to the meaning of each person's contribution with the utmost concentration. This involved going beyond the surface character of the data, patiently considering personal characteristics, e.g. self-expression and intonation. For instance, details passed over quickly had to be noted from verbatim transcriptions and from contextual information, in itself too detailed to be made explicit. An ethnographic computer programme, Textbase Alpha, was used for systematic support in the management of data.

In this research data is presented using two bipolar frames of reference (Fig. 3, p. 173, and Fig. 4, P. 176). Thus, two possible perspectives of analysis are illustrated, and heterogeneity of data is represented in the methodology. While this approach to data is unconventional (see the critique on homogeneity within the Literature Review), the research is a pre-experimental study to investigate an approach to self-discovery that is an alternative to institutionalisation. Data processing is a means of continuing qualitative exploration of personal research, rather than being a prelude to the construction of a systematic testing
instrument. While rigour is not sacrificed in personal research, the handling of such data could be subject to differing interpretations, i.e. where data is placed upon the bipolar frames of reference.

The use of a constructivist approach could be focussed within curriculum research, involving both the people who provide the service and those who use the service. Data selection may also be more focussed by applying a more structured elicitation of a person's repertoire of constructs, to explore how they are used in self-discovery. One possibility is a grid of personal situations, originally devised as a technique by Kelly (1955). Such a technique would have the advantage of being open to experimental design. The less bounded form of grid methodology used in this research is discussed in Chapter Five.

The recognition of constantly evolving views of people 'inside' and 'outside' of the research is significant in this study. The importance of 'insider' methodology lies in its contribution to research that seeks to contribute to multi-disciplinary practice and to be used by the people involved in it.