

The clinical gaze – ascribed gender(ed) identities in a mental health service context

Elisabeth Olin

Department of social work, University of Gothenburg, Gothenburg, Sweden

ABSTRACT

This article focuses on gender(ed) ascribed identities of service users in a mental health service context in Sweden. The empirical data were collected through observations of weekly team conferences. The examples can be described as ‘frozen images’ or ideal types in the sense that they illustrate the different ways service providers describe the service users’ problems at a certain time in a certain context. This article illustrates that the ‘the gaze’ of the service providers was value-laden, making moral judgements tied to the notion of responsibility. However, the same kind of behaviour or diagnoses can be accounted for in different ways and hence lead to different outcomes for the service user, which illustrates ‘severe mental illness’ as a stretchable phenomenon. The team discussions also mirror the service users’ strategies to handle professional and institutional power, that is, challenge the power position of professionals, with regard to the construction of service users as passive recipients or marked as ‘the other’. The predominant accounts and constructions of identities as victimized can be seen as part of a feminization process, closely related to weakness and dependence.

ARTICLE HISTORY

Received 17 June 2015
Accepted 19 July 2016

KEYWORDS

Mental illness; power positions; qualitative study; gender (ed) ascribed identities

Introduction

The present study, which is part of a larger research project, focuses on discussing how members of multi-professional psychiatric teams describe the service users, for example, their living situations, problems and treatment, or, more specifically, analyse how staff in their weekly team meetings contribute to the ascribed gender(ed) identities of service users and how these ascribed identities form the basis for professional decisions. In these encounters, the service user is psychically absent but indirectly ‘present’ through the professionals’ descriptions of them.

These kinds of professional meetings can illustrate situations and contexts in which categories are produced, maintained, modified and broken, according to the institutional logics, which shape the perceptions and ideology concerning treatment, support and control. Thus, is the sense of what is right or wrong, and also expectations and emotions do not only belong to the individual, but to the practice (Järvinen and Mik-Meyer 2003; Juhila et al. 2003; Reay & Hinings 2009; in Niccolini 2012). Language is doing (Guerin 2003; Scott-Hill 2003; Hall, Slembrouck, and Sarangi 2006), and how language is used affects identity constructions (Barron 2005). The way different groups, not least so-called marginalized groups, are spoken about mirrors current social conceptions of who they are and are not (Barron 2005). Service users identities are negotiated in and through different kinds of professional interaction (e.g. Juhila et al. 2003), which is of importance to

explore in order to gain a deeper understanding of how practical work in a mental health context gets done.

Background

During past decades, psychiatric care in Sweden, like in some other Western countries, has been subject to organizational, as well as ideological, changes. For example, the proportion of inpatient care sites has been reduced, while outpatient care has been extended. The majority of psychiatric care is currently run by community health, and inpatient psychiatric care is mainly located in somatic hospitals. In psychiatric outpatient care, multi-disciplinary teams are now a common form of organization (Levander et al. 2006; Ottosson 2007). These teams consist of service providers with different competences such as medical, psychological and social skills that aim to provide assistance of various kinds. However, studies show that the medical perspective is still usually dominant (Wilson and Beresford 2002; Blomqvist 2009).

It has been argued that there are advantages of working in multi-professional teams. Some of the aspects focused on are increased efficiency, the ability to take a holistic approach to the patients' problems, and improved ability to offer different and new types of interventions (Herman, Trauer, and Warnock 2002; Blomqvist 2009). However, studies also show that the multi-professional composition of teams may present difficulties such as lack of clarity about professional roles, a threat to professional autonomy and lack of cooperation between team members, as well as problems based on professional ethnocentrism and superiority (West, Tjosvold, and Smith 2003; Turner and Haslam 2012).

Studies show that mental health providers can influence service users' identities, especially those with a prolonged mental illness (Bülow 2004; Beresford 2005; Schön 2009). Thus, service providers risk attributing service users, especially those who do not accept the collective ascribed identity 'mentally ill', with stereotypical personality traits, i.e., as manipulative, uncooperative or lacking self-awareness (Wilson and Beresford 2002; Schön 2009). Accordingly, service providers, as well as the organizations within which they work, can be understood as part of a paradoxical context. On the one hand, they can provide treatment and important support that can improve the service users' living situations, but, on the other, there is a risk of stigmatizing the service users. Categorizations, such as 'mentally ill', can become a major, negatively 'marked', ascribed identity of individuals whose behaviour, characteristics and perceptions are exclusively interpreted as expressions of deviation (Goffman 1963). At the same time, however, categorizations such as 'mentally ill' can mean qualifying for various societal entitlements to services (Goove 2010; Kristiansen 2004).

Power positions

It is well documented that people with so-called mental health problems are part of a stigmatized and discriminated group in society, and persons with more severe symptoms are likely to be more exposed to discrimination (e.g. Sadow and Ryder 2008; Lundberg 2010; Link and Phelan 2014). This involves them being excluded from many social contexts and assigned various negative attributes and stereotypes (e.g. Kristiansen 2004), and gender(ed) identities.

Stigma is a matter of power, with certain decision makers contributing to constructing some groups differently (Goffman 1963). This has an impact on the identity and behaviour of the stigmatized persons and their opportunities to be included in society when it comes to employment, income, housing and social networks (Link and Phelan 2001, 2014; Sadow and Ryder 2008; Schön 2009). Ideas of blame, shame, inferiority and defect *can* weigh heavily on the identities of mental health service users, as can the issue of permanency that once identified and diagnosed as 'mentally ill', the users' identity and future can be ruined forever (Wilson and Beresford 2002). Thomas (2007, 2010) argues for a 'social relational' model of disability, taking into account psycho-emotional well-being and impairment effects. According to Thomas, as well as financial, material and social barriers,

individuals can be affected by hurtful and hostile comments of others. This can result in 'barriers to being', which can influence how a person feels about her/himself and what s/he may be or become (Reeve 2002; Thomas 2007, 2010). Individuals may relate in various ways to an ascribed identity, i.e., they may distance themselves from it or accept it (Goffman 1963; Corrigan and Matthews 2003; Islam 2008). The sociologist Castells (1997) argues that the social construction of identity always takes place in a context of different power positions in relationships. The issue at hand, he contends, is how, from what, by whom and for what certain identities are constructed. In this article, the construction of the service users' identities takes place in a psychiatric unit, which is an example of a dominant welfare institution.

Methodological approach

Study context

The empirical data were collected through observations of weekly team conferences held in a Swedish specialist psychiatric 'out-patient' care unit for service users with severe mental illness, in the sense that they had been diagnosed with psychotic disorders, situated in an urban area. The unit is organized with four multi-professional teams, and the service user belongs to one of them, depending of her/his residential address. The teams consist of doctors, psychologists, social workers, nurses, occupational therapists, psychiatric nurses and physiotherapists. Weekly meetings were held in each team when individual service users' problems, situations, treatment and progress were discussed. For some service users, only brief information was given, while others were discussed more extensively, with some recurring continually in the weekly discussions. According to Nikander (2003), professional meetings often have concrete outcomes on decisions about absent service users' living situations.

The duration of the meetings was two to three hours. The team members, except the doctor and psychologist, took turns chairing the team conferences. Each meeting began with the team members stating how many 'cases' (service users) they wished to discuss at the meeting. The discussions concerned service users already known to the team members as well as unknown service users, namely those referred by other health care providers. Thus, the team members also acted as gatekeepers, as they assessed which persons would qualify for acceptance to the unit.

Data collection and analyses

The empirical examples in this article come from detailed field notes from one-year non-participant observations carried out at the weekly meetings of the three teams at the psychiatric out care unit. The empirical data consist of 20 observations (40 hours) of team conferences. Most of the time service users were discussed, but there were also other forms of information exchanges, such as about work practices and conditions. At the observed meetings just over 125 service users were discussed, albeit to different degrees.

As it was not possible to tape-record the conversations, field notes were taken during the meetings. This led to some complications, however, as it was not possible to retain all the grammatical details, word order and semantics of the original discussion (Nikander 2003; Petersson 2013). A choice, therefore, had to be made about what to focus on and what to leave out, and the conversations were prioritized. The field notes were taken with the aim of staying as close to the conversations as possible. Here, the observers' extensive experiences of 'field-note taking' in both participant and non-participant observation studies were helpful (name deleted to maintain the integrity of the review process). Immediately after the observations, the field notes were written up in more detail and transcribed. Conventional spelling was used for the speech data and most of the non-verbal interaction was left out.

The empirical examples below of different problem descriptions by the service providers in the teams serve to illustrate how they contribute to the ascribed identities of service users with

mental health problems. These examples can be described as ‘frozen images’ or ideal types in the sense that they illustrate the different ways service providers describe the service users’ problems at a certain time in a certain context.

Qualitative content analysis (Patton 2002; Silverman 2006) was chosen to explore how the team members discussed the service users, and their situations and problems. In the first step, an empirically oriented approach was taken by reading through all the transcribed text several times in order to grasp the kinds of topics the team members brought up for discussion. Issues about the service users’ symptoms and diagnoses, relational and family problems, and housing and work life were frequently discussed. The team members also regularly ascribed different kinds of characteristics and traits to service users, especially those who were discussed often and thoroughly at the meetings. The next step of the analysis process, therefore, focused on ‘attributing episodes’, in both positive and negative ways. Different episodes, characterized by consensus or controversy within the team, were then analysed.

The Regional Ethics Review Board, University of Gothenburg, approved the design of the study. Apart from adhering to the general stipulations concerning research ethics, such as changing names and places, this article paid particular attention to limiting what the team members said about the service users in order to prevent the latter from being identified.

Personal tragedy, but ...

Mental illness can be understood as a continuum, with many people experiencing mental and emotional distress at some time in their lives (Wilson and Beresford 2002). In psychiatry settings, however, ‘mad persons’ and ‘not mad persons’ tend to be described as binary positions, and mental illness is understood in terms of individual pathology, disorder and permanency of defect often seen as a personal tragedy (Wilson and Beresford 2002). One group of service users is described in terms of loneliness and predominately tragic living situations. The following account is of Anna, a woman who has been harassed by local youths throwing stones at her house:

Social worker:	Well you can understand why the kids think it’s fun. She looks like a witch and when she shouts she sound like one too. She just shouts right out.
Social worker:	She always wants to know who you’re talking to. But then she twists it all into her misconceptions.
Psychologist:	But she trusts you – that’s good.
Psychologist:	Can’t she be moved to different accommodation?
Social worker:	Have tried for months but my ambitions are lower now.// She was born there and she says that the others are not going to win.
Psychologist:	But she’s the one who loses.
Occupational therapist:	I don’t think she thinks she’s worthy of anything better. But when she’s here she’s homesick and when she’s home she wants to be here.
Nurse:	Maybe she can’t be helped.

In the discussion among these service providers, an ambivalent understanding of Anna can be seen. On the one hand, Anna is described as a victim of violence and severe harassment while, on the other, the perpetrators are ‘excused’ because of her appearance and behaviour, which are expressed in terms of ‘she looks like a witch’ and ‘when she shouts she sounds like one too’, a gender-typical attribution (Barron 2004).

The social worker expresses that she has tried on several occasions to persuade Anna to move from her house but that she refuses, although she does not ‘want the others [the offenders] to win’. This could be seen as a reasonable standpoint and a conscious act, but the team members define her reaction as symptomatic of her perceived self-image as worthless, i.e., ‘I don’t think she thinks she’s worthy of anything better’. The team members also express doubts about their ability to help the woman, i.e., ‘Maybe she can’t be helped’. At the same time, however, this service user, who is said not to have any reliant relationships, is viewed as trusting the social worker, i.e., ‘But

she trusts you – that’s good’. Accordingly, even if the team members seem to have given up hope of improving Anna’s living situation, her loneliness and vulnerable situation, combined with her perceived confidence in the social worker, means that the service providers define themselves as a lifeline in the sense of ensuring that some of her most basic needs are met.

Another example framed as a personal tragedy is the story of Caspar. A nurse described his situation as follows:

He makes me cry. He is completely alone in the world. He was thrown out of his home when he was six years old and lived on the streets until he was twelve ... After a couple of years, he ran away to [country], was tortured and came to Sweden as a quota refugee ... Here he got a life, met a woman and had a child, but then he had a crisis. He just lay on the floor and couldn’t look after himself. He regressed. It’s a horrible story. He is illiterate ... but very clever. Despite everything he’s been through, he has drive. //He doesn’t get any real treatment here, and he doesn’t want to come here to the reception centre. He wants to meet me, so I meet him in other places.

The story of Caspar is mainly described in terms of a personal tragedy caused by circumstances beyond his control. Statements like ‘He makes me cry’ and ‘He is completely alone in the world’ underline his heart-breaking situation. After a short period of happiness, when Caspar got married and had a child, he is referred to as being back in a hopeless situation. But he is also described as ‘smart’, as a fighter and ‘having drive’, which can be seen as an aspect of ‘motivational tendency’ (Börjesson and Palmblad 2008). Even if the characteristics associated with strength and competence are mentioned, Caspar’s vulnerability is emphasized, which motivates the nurses to act in an unprofessional way by keeping in touch with him despite him no longer accepting being a service user at the unit.

Anna and Caspar are examples of service users who are described, in part, as tragic victims and portrayed mainly in stereotypical terms, which stresses their helplessness and inability. Due to their lack of mental or social ability, they are not held responsible for their situations (Guerin 2003; Nikander 2003). Even if there is a sense of hopelessness in the discussions, Anna and Caspar seem to evoke emotional involvement from the team members. Although the descriptions of Caspar includes strength and competence, characteristics that traditionally have been associated with masculinity, these are not focused on. Instead the professionals’ construction focuses on vulnerability and inability, a part of a feminization process. This underlines Anna’s and Caspar’s dependency, and contributes to the team members’ willingness to offer care and protection, something that can be understood as a manifestation of humanity but, somewhat paradoxically, in a paternalistic sense.

Easy to like, but ...

Other service users are described in somewhat contradictory terms, and the discussion has a negotiable character. Some of the team members highlight the persons’ behaviours as inappropriate and unacceptable, while others, especially the doctor, give an alternative explanation for some behaviours and/or reject the given problem definitions. By doing this, some negative attributes are reduced and the separation between ‘us and them’ becomes less clear (Link and Phelan 2014). Jonathan’s referral from another health care provider is discussed by the team members as follows:

- Doctor: [Reads from this journal] ... has taken drugs, was a criminal, has several neuropsychiatric diagnoses, but I don’t believe that. He wants to start over. He’s easy to like. Wants a certificate for a driving licence and disability pension ...
- Physiotherapist: [Ironically] So, he’s really sweet?
- Doctor: Yes, but the staff who were with him said that he can’t be together with others ... At the treatment centre where he lives now, he lives a bit separately from the others.
- Physiotherapist: But we have got no way of knowing if he has stopped doing drugs.
- Doctor: They deal with that at the treatment centre, where he has contact with a doctor.
- Nurse: Shouldn’t he have a contact here who can contact social services when he is discharged from the treatment centre.
- Doctor: Yes, he’s not an easy boy.

- Physiotherapy: The pictures are so different; it sounds almost like a psychopath. You think he is really sweet but ...
- Psychologist: Yes, it's surprising that it can be that way.
- Doctor: He needs a contact when he has finished at the treatment centre this summer. I can take him but not until after the summer.

Jonathan is described as having many problems, including addiction, criminality and neuropsychiatric diagnoses, i.e., subjected to a kind of *clinical evaluation or judgment* (e.g. Schalock and Luckasson 2005). There are different articulated opinions among the team members about the 'nature' of his problems, i.e., 'The pictures are so different; it sounds almost like a psychopath.' The doctor mentions the complexity of the problems in terms of 'Yes, he's not an easy boy' but says 'I don't believe that' referring to the fact that he has several neuropsychiatric diagnoses. Instead, the doctor empathizes with Jonathan's motivation to improve his life situation in terms of 'He wants to start over' and describes his personality as amiable in terms of 'He's easy to like.' A similar example is Thomas who lives together with his mother.

- Doctor: He used to be a henchman to the big boys. He was threatened; they thought he had grassed, but he says he hadn't. The psychiatrist he had seen before at a drug addiction centre said that it was pure paranoia, but it wasn't, they were after him. Not surprising that he had isolated himself, he was terrified. But when he met me he said it was the first time that someone had listened to him. He lifted his hood and said 'that it should take so many years to meet someone who understands, everyone else before spoke to mum, not me'.
- Nurse: It's not an easy situation, but he was probably wrongly referred. He doesn't really belong with us.
- Doctor: No, he doesn't belong in our target group, but, for God's sake, he must be allowed to belong to us. He has started trusting me after all.

As in the previous discussion, there are contradictory opinions among the team members concerning whether the person meets the criteria to be accepted as a service user at the unit. The nurse claims that he does not belong to the unit's target group, i.e., 'he was probably wrongly referred. He doesn't really belong to us'. The doctor agrees but argues for letting him in by questioning his diagnoses and referring to his confidence in her, i.e., 'He has started trusting me after all.'

These two examples mirror topics such as defining the nature of a person's problems, motivation and credibility (Guerin 2003; Nikander 2003). In both cases, the doctors had opposing views to those of the other team members. S/he ran with her/his line by questioning the psychiatric diagnoses given by other doctors. The doctors' superior power position increased the possibility of deconstructing the previous problem descriptions and replacing them with more 'normalizing' statements (Goffman 1963; Guerin 2003).

In great need of help, but ...

There are service users to whom the service providers ascribed identities and problems that exclude them from getting help at the unit. One common trait is to define them as unwilling to change, even though they had repeatedly been offered treatment and continually failed. They are, therefore, seen as untreatable and hopeless cases, and the moral attributions related to guilt and responsibility are present (Järvinen and Mik-Meyer 2003; Kristiansen 2004). Here, the service users' psychiatric diagnoses and problems are ignored while other problems such as different kinds of disabilities, social problems and challenging behaviour are highlighted. The service users are also described as uncooperative 'troublemakers' and impossible to help. Another common trait is that their families, especially the mothers, are described as problematic and awkward. One example is Eric, who had previously been referred to the unit but was refused because of his extensive drug abuse. A new referral has now been submitted:

- Physiotherapist: We now have a new referral which says that his psychiatric problems are worse than his drug addiction.
- Social worker: No, not him again!

Physiotherapist:	The patient wants to come here and the doctor who referred him thinks that specialist psychiatry is necessary.
Occupational therapist:	Good God!
Physiotherapist:	After the last referral, he was offered contact with an addiction clinic. It was very dramatic. The mother threatened to harm herself and others. The mother is 'damned difficult'!
Nurse:	He is the typical person nobody wants.
Doctor:	The mother is paid to take care of them.
Physiotherapist:	Yes, and now he's back again.
Doctor:	God, he feels violated giving a urine sample. He says that then he feels like a drug user. His mother arranges contact with the doctor. He is on 40 mg Stesolid a day. I suppose they share the dose.
Physiotherapist:	But, he is 18 years old.
Nurse:	It makes you wonder about the arrangement with the mother.
Social worker:	I suppose he's given up.
Physiotherapist:	That's terrible. It seems that everyone has given up.
Doctor:	Well, it's not a patient for us anyway. I will inform the doctor who referred him of that. By the way, I think when he says he's drug free he means just that day. Makes you wonder where he gets the money, heroin is expensive.

The description of Erik is interwoven with comments about his mother's moral character, i.e., 'His mother arranges contacts with the doctor. He is on 40 mg Stesolid a day. I suppose they share the dose.' The nurse defines Eric as 'He is the typical person nobody wants' and then expresses hopelessness, i.e., 'It's terrible, it seems that everyone has given up.' The doctor refuses the referral with the argument that Eric still suffers serious drug addiction by referring to her own construction of Eric as unreliable 'By the way, I think when he says he's drug free he means just that day.'

Another example is Sara, who has been discussed at many team meetings. She is now in compulsory treatment in a psychiatric ward in a hospital. Her doctor at the ward wants her to become a patient at the outpatient unit after completing her inpatient treatment. Sara is described as intellectually disabled, autistic and violent, and, combined with a complicated relationship with her mother, the team is very sceptical about accepting her as a service user:

Psychiatric nurse:	Mum is disappointed and angry with the health care services for not taking care of her. Mum can't cope with having her at home on leave, but they still send Sara home to her mother on leave.// She came to the ward because she was starting fires; it was deliberate. The staff say that her father lives abroad, but Sara says that he lives in Sweden with his new family.
Physiotherapist:	There must be other reasons than it being fun to start fires. Starting fires represents a lot ...
Psychiatric nurse:	Sara wants to move to her home country.
Doctor:	[Reads] I'm looking at your notes. It says here that mum is scared: Sara has threatened her. There's a lot going on with her – she needs someone who safeguards her interests and all kinds of things. We can give her the injections here but ... we won't do more than that!
Social worker:	Make a clear written note about that.

The descriptions of Sara are similar to those of Eric, painting a picture of an unreliable and unsympathetic person and, in Sara's case, even malicious and dangerous (Guerin 2003; Nikander 2003). Comments like 'She came to the ward because she was starting fires; it was deliberate' and 'mum is scared: Sara has threatened her' contribute to painting her personality as unsafe and violent. This, combined with an unwillingness to receive help, 'She just wants to be with her mum' presents her as a mad and unpredictable person (Goffman 1963; Wilson and Beresford 2002).

Eric and Sara are two examples of service users constructed as 'hopeless cases'. It is noteworthy that they are both young, just over 20 years old. The discussions focus mainly on their difficulties, and no positive characteristics were mentioned. Instead, they were described as individuals with extensive and permanent problems, manipulative behaviour, a lack of self-awareness and unmotivated to change their life situations. The doctor, especially, takes an active part in the stigmatization process. This also illustrates that persons who are unable to present themselves and their difficulties in a way that corresponds to the help system's criteria for admission already start off in a much worse

situation (Goffman 1963; Madsen 2005). But the value-laden 'gaze' also included the mothers, who were described as being responsible for an important part of their child's problems. Descriptions like being uncooperative, overprotective or exploiting their son's/daughter's situation are characteristics often ascribed to mothers of children with special needs (Read 2000; Olin 2003; Ryan and Runswick-Cole 2008, 2009).

Normality and othering

The concept of normality, embedded in the medical model, has been at the core of the othering process, which shapes the understanding of mental illness as a moral deficit (Beresford 2005). This article illustrates that 'the gaze' of the service providers was value-laden, making moral judgements tied to the notion of responsibility. However, the same kind of behaviour or diagnoses can be accounted for in different ways and, hence, lead to different outcomes for the service user, which illustrates 'severe mental illness' as a stretchable phenomenon (Wilson and Beresford 2002). The construction of otherness takes place by dominant groups that have superior power positions and are characterized by stereotyping and invisibility, which Young (1999) calls paradoxical oppression. In a psychiatric context, the service providers have the power to make decisions that have a great impact on the service users' life situation. The construction of otherness is also about moral judgements, as it has been shown that professionals react morally according to whether the individual is held responsible for her/his situation. If the problems can be explained by a lack of mental or physical ability, alternatively be located outside the individual, s/he is not blamed for her/his plight (Guerin 2003; Nikander 2003). Once the individual has been constructed as an active decision maker, however, s/he also becomes morally responsible for her/his actions (Guerin 2003). This, together with a socially acceptable and desirable behaviour, particularly in relation to staff, as well as a 'motivational tendency' allows professional boundaries to be stretched and extra efforts may be granted (Järvinen and Mortensen 2005; Börjesson and Palmblad 2008).

However, this does not mean equal power positions between service providers and service users. People with mental health problems are in a vulnerable position because of their dependence on adequate assistance. Normative expectations, as part of social control, are so embedded in our societies that they are not experienced as controlling by those who are controlled or by the controllers. Mental health providers have control over information and connections to the outside world, and 'own' the definition of what is 'normal' and 'real' (Kristiansen 2004).

A superior power position is inherent in the roles of professionals generally, but professionals do not constitute a homogeneous group with respect to their power position nor in how they use this position (Barron 2001). The doctor sometimes had an opposing view to that of other team members and successfully appeared to persuade the other team members to include the presumptive service user in the unit's target group. This apparently effective strategy, which demonstrates a superior power position, includes redefining previous destructive problem descriptions of the service users with more normalizing explanations. The doctor was an important agent in excluding persons from the unit, and the opposite strategy was then used, namely to contribute to a stigmatizing construction. It was clear, as shown in other studies, that the doctors had the most powerful position in making the final decision.

The descriptions of the service users were characterized by an individualized view of mental illness, sometimes described as a personal tragedy, albeit to different extents. It was also apparent that the decisions and actions of the service providers had an emotional base. If the professionals expressed feelings of sympathy and pity towards a service user this could lead to increased involvement, while expressed feelings of anti-sympathy could result in a reluctance to help (Guerin 2003). The team discussions also mirrored the service users' strategies to handle professional and institutional power (Goffman 1963; Castells 1997). These expressed strategies can be understood as posing a threat to the institutional stability, i.e., challenging the power position of professionals with regard to the construction of service users as passive recipients or marked as 'the other'. This

could be understood as one of Castells's identity constructions, legitimizing identity, which is introduced and used by dominant institutions in society and of which psychiatric organizations are part, in order to rationalize and extend their domination with regard to social actors.

The conception of an independent individual has been described as an illustration of being a man, physically, cognitively and otherwise intact, which has been referred to as a hypothetical being (Shakespeare 2006). The concept of interdependence can serve as a reminder that both parties give and receive in a caring relationship and can serve to prevent a prejudiced view of people with mental health problems as 'burdensome dependents' (Juhila 2003).

Gendered identities

It has been emphasized that gender(ed) identities are naturalized fictions rather than natural entities, that is, always prone to dissonance and uncertainty. Acknowledging this uncertainty, or lack of coherence, enables gender to be decoupled from sex (Lloyd 2005). The above referred to examples of service providers' discussions of service users can be understood in terms of ascribing the latter gendered identities. The predominant accounts and constructions of identities as victimized can be seen as part of a stereotypical feminization process, that is, closely related to weakness and dependence (Barron 2004). This applies to the ways of referring to the female and the male service users, although personal appearances are only referred to when it comes to women, which can be interpreted as *gender typical*. Another example of gender stereotyping is the way that mothers are held accountable by the service providers for not parenting in the prescribed way and even being accused of producing a dysfunctional child (Ryan and Runswick-Cole 2008, 2009). Inherent in what can be referred to as 'the clinical gaze' among the professionals in this study is a sense of concern for the vulnerability of the discussed service users combined with a sense of gendered clinical evaluation.

Concluding remarks

It is worth repeating that those involved in the conversations exemplified here are exclusively service providers, no service users make their own voices heard. The service users' behaviours, personalities and appearances are indirectly referred to in the professionals' accounts. These indirect referrals are of value in furthering the understanding of how the ascribed identities of the service users are constructed, and show that the professional decisions are influenced by their social and moral conceptions of the service users' individual qualities and character traits. In this study, detailed interaction-based analysis was used, which gives an immediate access to how sensitive issues about service users identities, problems, life situation are raised and solved in a mental health context and illustrates existing tensions within a particular area of professional rationality and decision-making. This kind of, detailed analyses of professional and institutional practice offer valuable knowledge which can provide a basis upon which future practices can be modulated in order to correspond with service users' requirements and rights, and professional responsibilities.

This study on ascribed gender(ed) identities in a mental health service context has inspired to further investigation of some of the issues at hand, exclusively from service users' perspectives. It has been argued that mental health service providers may lack understanding of service users' perspectives and needs, i.e., according to their psychosocial situation, relationships, resources and prospects (Svavarsdottir, Júlíusdóttir, and Lindqvist 2013).

The focus is then on how service users view the interaction with service providers and, indeed, how they view themselves, i.e., their self-identity. In order to further the understanding of the self and self-identity, studies that explore what has been referred to as 'resistance identity' (Castells 1997) can be of great value and relevance. Castells defines this kind of identity as produced and resisted by those actors who are in devalued and/or stigmatized positions. As shown by Watson (2002), awareness of the self can be premised on a notion of what one feels oneself to be, not necessarily what others suggest one should be.

Acknowledgements

I would like to thank the informants for participating in this study, and professor Karin Barron, Department of Social Work, University of Gothenburg for helpful comments.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Elisabeth Olin, PhD, associate professor at the Department of Social Work, University of Gotheburg. Her research interest are social aspects of everyday life and living conditions for disabled people with focus on social relationships, social identities and power dimensions.

References

- Barron, K. 2001. "Autonomy in Everyday Life, for Whom?" *Disability & Society* 16 (3): 431–447.
- Barron, K. 2004. "Genus och funktionshinder" [Gender and Disability]. In *Genus och funktionshinder* [Gender and Disability], edited by K. Barron, 15–47. Lund: Studentlitteratur.
- Barron, K. 2005. "I Am, and I Am Not: Identity, a Multifaceted Concept and Social Phenomenon." In *Resistance, Reflection and Change. Nordic Disability Research*, edited by A. Gustavsson, J. Sandvin, R. Traustadottir, and J. Tössebro, 163–174. Lund: Studentlitteratur.
- Beresford, P. 2005. "Social Approaches to Madness and Distress. User Perspectives and User Knowledge." In *Social Perspectives in Mental Health, Developing Social Models to Understand and Work with Mental Distress*, edited by J. Tew, 32–52. London: Jessica Kingsley.
- Blomqvist, S. 2009. "Kompetensutnyttjande i mångprofessionella team" [Using Skills in Multi-professional Teams]. PhD diss., Linköping University.
- Börjesson, M., and E. Palmblad. 2008. *Strultjejer, arbetssökande och samarbetsvilliga. Kategoriseringar och samhällsmoral i socialt arbete* [Troublesome Girls, Job Seekers and Cooperators. Categorizations and Social Morality in Social Work]. Malmö: Liber.
- Bülow, P. 2004. "Efter mentalsjukhuset" [After the Mental Hospital]. PhD diss., Linköping University.
- Castells, M. 1997. *The Information Age, Economy, Society and Culture. Vol. II of the Power of Identity*. Malden, MA: Blackwell.
- Corrigan, P. W., and A. K. Matthews. 2003. "Stigma and Disclosure: Implications for Coming Out of the Closet." *Journal of Mental Health* 12 (3): 235–248.
- Goffman, E. 1963. *Stigma. Notes of the Management of Spoiled Identity*. Harmondsworth: Penguin Books.
- Gove, W. R. 2010. "The Career of Mentally Ill, an Integration of Psychiatric Labelling, Social Construction and Lay Perspectives." *Journal of Health and Social Behaviour* 45: 357–375.
- Guerin, B. 2003. "Language Use as Social Strategy: A Review and an Analytic Framework for the Social Sciences." *Review of General Psychology* 7 (3): 251–298.
- Hall, C., S. Slembrouck, and S. Sarangi. 2006. *Language Practice in Social Work; Categorisation and Accountability in Child Welfare*. London: Routledge.
- Herman, H., T. Trauer, and J. Warnock. 2002. "The Roles and Relationships of Psychiatrists and Other Service Providers in Mental Health Services." *Australian & New Zealand Journal of Psychiatry* 36: 75–80.
- Islam, Z. 2008. "Negotiating Identities: The Lives of Pakistani and Bangladeshi Young Disabled People." *Disability & Society* 23 (1): 41–52.
- Järvinen, M., and N. Mik-Meyer. 2003. *At skabe en klient. Institutionelle identiteter i socialt arbejde* [To Create a Client. Institutional Identities in Social Work]. Copenhagen: Hans Reizels Forlag.
- Järvinen, M., and N. Mortensen. 2005. "Det magdfulle møde mellem system og klient: teoretiske perspektiver" [The Powerful Encounter between Systems and Client: Theoretical Perspectives]. In *Det magdfulle møde mellem system og klient* [The Powerful Encounter between System and Client], edited by M. Järvinen, J. E. Larsen, and N. Mortensen, 9–27. Aarhus: Aarhus Universitetsforlag.
- Juhila, K. 2003. "Creating a 'Bad' Client: Disalignment of Institutional Identities in Social Work Interaction." In *Constructing Clienthood in Social Work and Human Services. Interaction, Identities and Practices*, edited by C. Hall, K. Juhila, N. Parton, and T. Pösö, 83–95. London: Jessica Kingsley.
- Juhila, K., T. Pösö, C. Hall, and N. Parton. 2003. "Introduction: Beyond a Universal Client." In *Constructing Clienthood in Social Work and Human Services. Interaction, Identities and Practices*, edited by C. Hall, K. Juhila, N. Parton, and T. Pösö, 11–26. London: Jessica Kingsley.

- Kristiansen, K. 2004. "Madness, Badness and Sadness Revisited. Ontology Control in 'Mental Health Land'." In *Gender and Disability Research in the Nordic Countries*, edited by K. Kristiansen and R. Traustadottir, 365–393. Lund: Studentlitteratur.
- Levander, S., H. Adler, O. Gefvert, and E. Tuninger. 2006. *Psykiatri: En orienterande översikt* [Psychiatry: An Exploratory Overview]. Lund: Studentlitteratur.
- Link, B. G., and J. C. Phelan. 2014. "Mental Illness Stigma and the Sociology of Mental Health." In *Sociology of Mental Health Selected Topics from Forty Years 1970s-2010s*, edited by R. J. Johnson, R. J. Turner, and B. G. Link, 75–100. Cham: Springer International Publishing.
- Lloyd, G. 2005. *Problem Girls: Understanding and Supporting Troubled and Troublesome Girls and Young Women*. London: Routledge Falmer.
- Lundberg, B. 2010. "Erfarenheter av diskriminering och stigmatisering bland personer med psykisk sjukdom" [Experiences of Discrimination and Stigmatization among People with Mental Illness]. PhD diss., Lund University.
- Madsen, B. 2005. *Socialpedagogik. Integration och inklusion i det moderna samhället* [Social Pedagogy. Integration and Inclusion in the Modern Society]. Lund: Studentlitteratur.
- Nicolini, D. 2012. *Practice Theory, Work, and Organization*. Oxford: Oxford University Press.
- Nikander, P. 2003. "The Absent Client: Case Description and Decision Making in Interprofessional Meetings." In *Constructing Clienthood in Social Work and Human Services. Interaction, Identities and Practices*, edited by C. Hall, K. Juhila, N. Parton, and T. Pösö, 112–128. London: Jessica Kingsley.
- Olin, E. 2003. "Uppbrott och förändring. när ungdomar med utvecklingsstörning flyttar hemifrån" [Break-up and change. When young disabled people move away from home]. PhD diss., University of Gothenburg.
- Ottosson, J.-O. 2007. *Psykiatriboken* [The Book of Psychiatry]. Stockholm: Liber.
- Patton, M. Q. 2002. *Qualitative Research and Evaluation Methods*. London: Sage Publications.
- Petersson, F. J. M. 2013. "Excusing Exclusion: Accounting for Rule Breaking and Sanctions in a Swedish Methadone Clinic." *Drug Policy* 24 (6): 99–104.
- Read, J. 2000. *Disability, the Family and Society: Listening to the Mothers*. Buckingham: Open University Press.
- Reay, T., and C. R. Hinings. 2009. "Managing the Rivalry of Competing Institutional Logics." *Organization Studies* 30 (6): 629–652.
- Reeve, D. 2002. "Negotiating Psycho-Emotional Dimensions of Disability and Their Influence on Identity Constructions." *Disability & Society* 17 (5): 493–508.
- Ryan, S., and K. Runswick-Cole. 2008. "Repositioning Mothers: Disabled Children and Disability Studies." *Disability & Society* 23 (3): 199–210.
- Ryan, S., and K. Runswick-Cole. 2009. "From Advocate to Activist? Mapping the Experiences of Mothers of Children on the Autism Spectrum." *Journal of Applied Research in Intellectual Disabilities* 22 (1): 43–53.
- Sadow, D., and M. Ryder. 2008. "Reducing Stigmatizing Attitudes Held by Future Health Professionals: The Person is the Message." *Psychological Services* 5 (4): 362–372.
- Schalock, R., and R. Luckasson. 2005. *Clinical Judgment*. Washington, DC: American Association on Mental Health.
- Schön, U.-K. 2009. "Kvinnors och mäns återhämtning från psykisk ohälsa" [Women's and Men's Recovery from Mental Illness]. PhD diss., Stockholm University.
- Scott-Hill, M. 2003. "Deafness/Disability-Problematising Notions of Identity, Culture and Structure." In *Disability, Culture and Identity*, edited by S. Ridell and N. Watson, 86–104. London: Pearson, Prentage Hall.
- Shakespeare, T. 2006. *Disability Rights and Wrongs*. London: Routledge.
- Silverman, D. 2006. *Interpreting Qualitative Data. Methods for Analyzing Texts, Talk and Interaction*. London: Sage.
- Svavarsdottir, S. J., S. Júlíusdóttir, and R. Lindqvist. 2013. "A Holistic View in Psychiatric Rehabilitation: The Effects of Structure in Psychiatric Institutions." *Journal of Social Work in Disability & Rehabilitation* 14 (4): 272–294.
- Thomas, C. 2007. *Sociologies of Disability and Illness. Contested Ideas in Disability Studies and Medical Sociology*. Basingstoke: Palgrave Macmillan.
- Thomas, C. 2010. "Medical Sociology and Disability and Disability Theory." In *New Directions in the Sociology of Chronic and Disabling Conditions. Assaults on the Lifeworld*, edited by G. Schambler and S. Schambler, 37–56. Basingstoke: Palgrave Macmillan.
- Turner, J. C., and A. Haslam. 2012. "Social Identity, Organization, and Leadership." In *Groups at Work*, edited by M. E. Turner, 25–66. New York: Routledge.
- Watson, N. 2002. "Well, I Know This Is Going to Sound Very Strange to You, But I Don't See Myself as a Disabled Person: Identity and Disability." *Disability & Society* 17 (5): 509–527.
- West, M., D. Tjosvold, and K. G. Smith. 2003. *International Handbook of Organizational Teamwork and Cooperative Working*. Chichester: John Wiley & Sons.
- Wilson, H., and P. Beresford. 2002. "Madness, Distress and Post-Modernity: Putting the Record Straight." In *Disability/Postmodernity: Embodying Disability Theory*, edited by M. Corker and T. Shakespeare, 143–158. London: Continuum.
- Young, I. 1999. *Justice and the Politics of Difference*. Oxford: Princeton University Press.