The language of mental health nursing reports: firing paper bullets?

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A great deal of the caring work of nursing is accomplished and mediated through language. This paper attempts to characterize some of this language in quantitative and stylistic terms in an attempt to characterize the genre of nursing report language. Nursing students ($n = 26$) and graduate nurses ($n = 3$) viewed a videotape of a person being interviewed by a psychiatrist and produced written reports. These showed a large proportion of words relating to the person and to feelings and needs, compared to existing databases of the English language in general. The language produced by the participants also contained many modal or modifying words and is similar to spoken rather than written English in terms of the proportion of lexical content. There was much diversity in their descriptions and the vocabulary used to refer to the client. Graduate nurses showed more scepticism of the evidence provided by the video and advocated more investigation and questioning of the client. The use of standard forms and techniques of expression suggests that these reports were assembled on a language production line. Finally, we advocate a more systematic approach to educating nursing students about the power of the language they use.

Keywords: language, mental health, nurse training, nursing students

INTRODUCTION

Recently, interest has grown in the 'textually mediated reality' of nursing (Cheek & Rudge 1994). Since language is a powerful social practice (Fairclough 1989), or indeed a 'loaded weapon' (Bolinger 1980), it is vital that more research is carried out to examine how nursing language exerts power within the constraints of its own generic conventions and within the broader set of power relations which exist between doctors, nurses and patients (Fisher

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1995, Shotter 1997). This paper begins to describe and analyse nursing language practices, based on a corpus of written reports made by nursing students and qualified mental health nurses. The analysis is not exhaustive, nor would any single description of language cover all language use situations. However, we will: highlight some shared features of these texts; compare nursing language to English in general; note differences between individual writers; and locate discrepancies between nursing students' accounts and those of their qualified counterparts.

The importance of studying professional language and its acquisition becomes clear when we consider what it means to be socialized into an occupational role. The received view of occupational socialization in health care stresses the adoption of values, vocabularies and professional identities (e.g. Becker *et al.* 1961) and the formal curriculum of training. In theory, the qualified professional is distinctive, having been transformed into a 'participating effective member of the organization' (Nelson & Quick 1994, p. 499). Thus, *congruence* is achieved between the newcomer and the profession. This view is also found in the social psychology of group membership. For example, Tajfel (1982) argued that we make fundamental distinctions between members of our own in-group and outsiders.

This received view of professional socialization is problematic. Firstly, there have been upheavals in the health sector and changes in training curricula. Nursing struggles to define its area of expertise and resist market forces (Gavin 1997). A dynamic equilibrium is maintained between governments, managers, accountants and administrators as well as nurses and doctors themselves. This has led to diverse opinions about nursing philosophy and practice, and the ideologies and cultures within it are only disclosed by careful scrutiny (for example Fagermoen 1997, Suominen *et al.* 1997, Taylor 1997).

The second reason why the received view is problematic is that it tells us little about how language will be used to deal with specific nursing problems. Certainly, a technical vocabulary is employed by professionals, yet much research on institutional language emphasizes that mundane features and vocabularies predominate (Sarangi & Slembrouck 1996, Gunnarson *et al.* 1997). There is work which examines 'baby talk' used with elderly persons (Caporael *et al.* 1983), negotiation between patients and professionals (Gill & Maynard 1995) and informal communication between trainee professionals (Becker 1993), all of which emphasize lay terminology rather than a technical register. Yet we know little about the language into which the intending professional is socialized.

The relationship between the profession and language is complex. Being a professional is defined by practice rather than language itself. Indeed, there is concern that technological features of the profession have prevailed over the care-orientated ones (Stevens & Crouch 1995). As Bourdieu argues, language does not create its own power: 'What creates the power of words and slogans, a power capable of maintaining or subverting the social order, is a belief in the legitimacy of words and those who utter them. And words alone cannot create this belief' (Bourdieu 1991 p. 170). Power, values and ideology lie behind language and it is occupational socialization which inculcates these. However, their operation is seen through language itself as an organized social practice.

We can find, as other authors have suggested, some consistent features or genres of nursing language. For example, Proctor *et al.* (1996) identify the 'comfort talk register', which nurses used to encourage patients to endure their distress. Likewise, we shall present evidence that the language of mental health care obeys generic conventions. We shall also show nursing students acquiring their professional vocabularies and registers, and examine the potentially incarcerative aspects of their language (Crawford *et al.* 1995). Like Encandela (1991), Bhatia (1993) and Boden (1994), we believe that the language of reports reflects the context of broader social relations, structures of authority and communities of sense-making. In nursing it is vital that such language use is more thoughtfully investigated. Here, we examine the linguistic features of reports made by Project 2000 students beginning their studies in mental health. In their gradual socialization into the profession they had acquired some nursing culture, but had not yet experienced clinical settings. This allowed comparison with qualified nurses, to see how they were trying on their new 'linguistic uniforms'.

Writing reports about individuals is central to mental health nursing practice. These reports become part of a biographical file of the individual client, communicating assessments, plans, interventions and evaluations across time and between a variety of agents or services. Increasingly, scholars are examining how telling stories about reality involves many linguistic devices to make our accounts persuasive, believable and convincing (Wooffitt 1992, Potter 1996). Language which purports to tell us about reality is meticulously organized in terms of style and vocabulary. There is 'order at all points' (Psathas 1995), and our analysis 'highlights the tactical aspect of conventional language use, specifying the ways members of a particular speech community assign restricted value to various aspects of language use when operating in a particular genre' (Bhatia 1993 p. 26). Thus we can accumulate evidence about the representations of patients constructed by nursing students.

The nurses participating in our study were asked to make a report about the mental health of an individual for a professional readership. These reports were generated solely to isolate linguistic features which mark mental health nursing report language and locate any developments in report making techniques between the beginning of Project 2000 training and professional practice.

METHODOLOGY

Participants

Twenty-six second-year undergraduate nursing students at a Midlands university provided data during their 'Introduction to Mental Health', part of the Common Foundation Programme. In addition, three graduate nurses from this course, now working in mental health, were included to enable comparisons.

Exercise

Participants observed a 10-minute video in which a person (the 'subject') described the nature of his problems to a psychiatrist. Participants were then given the following instructions:

> Observe the interview on the video and whilst doing so make a judgement as to whether or not you would recommend this person for hospitalization. In about 500 words indicate the main observations you noted and the reasons for your decision. It is important to approach your writing as if it were to be read by other professional colleagues.

The resulting texts were transcribed to form the student report (SR) corpus containing 5539 words.

Analysis

The analysis firstly involved producing a quantitative account of the word usage in the SR corpus and comparing this with existing databases of the English language. Secondly, we analysed features such as modal or modifying terms used, nomenclature, semantic sets, binomial expressions, lexical density and reported speech. We then compared student and qualified participants' reports.

RESULTS AND DISCUSSION

Vocabulary frequency counts and comparison with other samples of English

Our investigation of vocabulary in the SR corpus began with an examination of word frequency, as represented in Table 1. We then compared this frequency list with the COBUILD Corpus (CC) and the Bank of English (BoE), two major databases of the English language (Table 2). In both tables we distinguish between lexical or content words (bold face) and grammatical items. Lexical items include nouns, verbs, adjectives, adverbs and pronouns. Grammatical items cement the lexical items together and include prepositions, conjunctions, auxiliary verbs, articles and negatives.

The data in Table 1 suggest that the texts belong within the register of mental health nursing reports. When we asked a number of 'observers' to guess what the texts were about from the table, they agreed that mental health nursing was likely. Thus, lexical analysis can convey information about the dominant lexical features of texts, and shows that the students are participating in a distinctive genre or register. This is suggested by the frequency of variations of the word *feel* (*feels/feeling/feelings/felt*) which are used in terms of the interviewer (*feel* = think) and interviewee (*feels* = experiences). When all these variations are combined the base term or 'lemma' enters the top 10 of our league table, a place generally reserved for the more common grammatical rather than lexical items, as shown in the CC and BoE in Table 2. The most frequent lexical items are commonly pronouns and the copula (*is, was*). Also frequent in the league table are: *he* (jumped 12 places to the most frequent item) and *be* (jumped 9 places). The position of *he* at top frequency is most significant, and reflects the nature of the SR corpus and its clear focus on its subject.

Table 1 provides further quantitative features which can be understood as part of the genre, register and topic of the SR corpus:

(a) *Needs* is the prominent verb after *feel*, and represents a strong focus on assessment of the individual's requirements, or inferences about his state of mind. Participants are inferring these properties as fundamentally part of the 'patient'. They are venturing 'under the skull' into vocabularies of intrapsychic constructs to explain the patient's behaviour (Garfinkel 1967, Potter & Wetherell 1987).

(b) The most frequent lexical items are the nouns *life, family, depression, hospital, patient* and the adjectives *depressed* and *trapped* which tie down the content even more specifically. These clues might have helped identify the SR corpus as originating from a mental health care context.

(c) There is a high frequency of modal auxiliaries: *may, would, could, can, can't, should, will, might*. There are also two prominent modal verbs: *appears, seems*. Modality concerns possibility, probability, likelihood or intention. Of the terms generated by the students, *may, might, appears* and *seems* are more sceptical than *would, could, can, can't, should* and *will*. This may be socially significant, in that students are oscillating between indecisive and decisive statements. Moreover, modal statements are often part of the kind of academic language appropriate to a classroom exercise. Whilst showing they are aware of the features in question, they forestall potential conflicts with other possible interpretations by the researchers. They are pushing their descriptions down the 'hierarchy of modalization' (Latour & Woolgar 1986, Potter 1996). This has been noted as a feature of the language of disempowered groups (e.g. Lakoff 1975), and corresponds to the position of nurses in hospital hierarchies (Boden 1994, Fisher 1995). Modalizing terms are also a way of

Table 1 A lexical league table of the SR corpus: top frequencies among lexical (bold face) and grammatical items

Frequency order of items											
1–20		**21–40**		**41–60**		**61–80**		**81–100**		**101–120**	
he	312	**feels**	41	but	21	**get**	16	**low**	13	are	10
to	237	for	40	**himself**	21	more	16	any	12	because	10
and	170	from	38	**hospitalisation**	21	which	16	been	12	being	10
the	152	with	36	can't	20	will	16	**benefit**	12	**come**	10
his	135	**life**	34	**man**	20	**contact**	15	**community**	12	**condition**	10
that	129	at	33	no	20	did	15	**cope**	12	doesn't	10
is	98	may	30	on	20	**feeling**	15	do	12	**getting**	10
be	96	**family**	29	should	20	over	15	does	12	**interview**	10
of	93	would	29	some	20	**trapped**	15	how	12	**little**	10
this	92	**depressed**	28	self	19	**way**	15	**lack**	12	might	10
in	80	could	27	**support**	19	**better**	14	**client**	11	**questions**	10
a	77	**depression**	27	very	19	**end**	14	**counselling**	11	**said**	10
I	70	**hospital**	27	**appears**	18	**gentleman**	14	**existing**	11	away	9
as	61	can	25	**feelings**	18	**interviewer**	14	however	11	**coping**	9
not	61	so	24	if	18	there	14	into	11	**felt**	9
him	54	also	23	**think**	18	**time**	14	just	11	**harm**	9
was	45	**needs**	23	about	17	although	13	**live**	11	**know**	9
has	44	an	22	**down**	17	**eye**	13	**long**	11	need	9
feel	43	have	22	**help**	17	**he's**	13	**suicide**	11	**seems**	9
it	43	**patient**	22	or	17	**job**	13	up	11	**therapy**	9

The distinction between lexical and grammatical items may depend on usage. For example, 'down' is lexical rather than grammatical because it is used adjectivally (e.g. 'he was down') rather than as a preposition (e.g. 'he fell down the stairs').

Table 2 A comparison of top frequency items found across corpora

	SR Corpus 1995 5539 words		COBUILD Corpus 1987 18 million words		Bank of English 1993 120 million words	
1	**he**	312	the	1023506	the	70333331
2	to	237	of	503284	of	3316470
3	and	170	and	475864	to	3076898
4	the	152	to	448378	and	2873369
5	his	135	a	388354	a	2612347
6	that	129	in	311996	in	2324803
7	**is**	98	that	190007	that	1317203
8	be	96	**was**	186792	**it**	1107691
9	of	93	**it**	180642	**is**	1089753
10	this	92	**I**	170090	for	1036117
11	in	80	**he**	155762	**was**	949413
12	a	77	**is**	149514	**I**	909313
13	**I**	70	for	138753	**he**	860841
14	as	61	with	118376	on	825988
15	not	61	as	116429	with	753449
16	him	54	on	115486	as	711221
17	**was**	45	had	109835	be	652684
18	has	44	**you**	109591	**you**	644700
19	**feel**	43	be	102401	at	612654
20	**it**	43	his	99140	by	598407

Lexical items or content words are distinguished from grammatical items by bold face.

'hedging'. This is a strategy to 'ward off and defeat in advance doubts and negative typifications which might result from intended conduct' (Hewitt & Stokes 1975 p. 3). Highly 'hedged' language does not prematurely commit the writer to a potentially contentious course of action. Perhaps our participants are not so much firing paper bullets as firing blanks — using language which says very little.

(d) A variety of labels are attached to our subject: *man, patient, gentleman, client* and *person*. Each of the 26 students chose one, two or occasionally three labels for the subject: five exclusively used *man,* four exclusively used *patient,* three exclusively used *gentleman* and two exclusively used *client*

In a professional group we might expect more homogeneity. There is a tension between professional (non-gendered) and lay (gendered) descriptions of personhood.

(e) There are some prevalent semantic sets:

- Participants — patient, man, gentleman, interviewer, client.
- Social status — life, family, hospital, job, community.
- Negative affect — depressed, depression, down, trapped, low.
- Negative action — end, suicide, harm.
- Negative content — can't, no, lack (eye contact), doesn't, little.
- Nursing actions — support, counselling, therapy.
- Positive effects — help, better, benefit.
- Cognition — feels, needs, feeling, cope, coping, felt, know, need, seems.

These semantic sets summarize and transform the information into something which is manageable in terms of psychiatry's concepts, categories and working routines. Recording information is crucial to the activity of transforming the patient's problems into manageable ones (Berg 1995, 1996). It 'affords the creation of a re-presentation of the patient' (Berg 1996 p. 505).

Binomial expressions using *and* and *or*

In the nursing students' texts, 'binomial expressions' such as *anxious (/-iety) and depressed (/-ion)* were a significant feature. Mellinkoff (1963) and Gustafsson (1984) distinguish two categories of binomials in legal language: those that are merely 'worthless doubling' of synonyms (Mellinkoff 1963 p. 349) and those that are needed for technical accuracy because 'to a lay person the two words mean the same thing, but to members of the [legal] profession there is a clear distinction' (Gustafsson 1984 p. 134). In addition, detailed recollections are more convincing (Bell & Loftus 1988, 1989). In accounts of hard-to-believe phenomena, details make the teller's account more vivid (Wooffitt 1992). The same process may be at work when participants list descriptive terms. Perhaps these binomials are not 'worthless doubling' and do important work as features of the nursing register.

The binomials used by the participants related either to the interviewee and his situation, his personal problematic feelings, or interventions and solutions to the problems.

Interviewee and situation

family ***and*** X (4 examples)

where X equals: *home, job, work, friends*

life ***and*** *himself* (2 examples)

Feelings and assessment

anxious (/-iety) ***and*** *depressed (/-ion)* (7 examples)

X ***and*** *depressed (/-ion)* (7 examples)

where X equals: *anxious, anxiety, down, low*

X ***and*** *courage* (2 examples)

where X equals: *confidence, control*

feelings ***and*** X (2 examples)

where X equals: *problems* and a clause

nervous ***and*** X (3 examples)

where X equals: *very depressed, trapped, possible depression*

suicide ***or*** *self-harm* (2 examples)

Interventions, solutions, responses

support ***and*** X (3 examples)

where X equals: *counselling, rehabilitation, supervision*

X ***and*** *counselling* (2 examples)

where X equals: *psychotherapy, support*

X ***and*** *treatment* (2 examples)

where X equals: *medication, observation*

Where there is more than one example of the same pair then this is a 'fixed expression' (Moon 1994) which has general recognition and usage. Most binomials are in the Feelings and Assessment category, indicating a focus on problems located in the individual. In general, English contains a richer set of terms for describing individuals than it does situations or places (Allport & Odbert 1936). Moreover, there is a strong tendency for observers to emphasize the role of the person and discount the role of the situation (Ross 1977). The three categories of binomials and the assessments and interventions of nursing correspond. Students are producing accounts of the patient which emphasize that his problems are susceptible to intervention and in which psychiatry should have a stake.

Adverbs and the variation in the assessment of the subject's condition

The adverbs which occur most frequently in the nursing texts fall into categories described by Johansson (1993) of (a) degree and extent; (b) emphasis; (c) time; (d) evaluation of truth; (e) quality and state. The category of degree and extent is linked to diagnoses (*severely* or *significantly* depressed) and appearance (*slightly* untidy, slouched *slightly*). One participant describes the subject's appearance as *smartly dressed*, yet another says *slightly untidy*. The diagnostic function also features in the category quality and state (*clinically*), rather like the oscillation between high and low modality noted earlier. Adverbs of emphasis (*obviously, clearly, particularly, only, simply, really, specifically*) all lend a rhetoric of certainty. However, adverbs which evaluate truth (*apparently, possibly*) are sceptical about phenomena.

Most participants referred to the subject as *depressed* (28 occurrences in 26 texts). This adjective was modified with a variety of terms: *clinically, very, severely, significantly, moderately*. These terms appear to be used synonymously and without precise agreement, suggesting they were applied in an arbitrary fashion. Another example is the use of lay terms such as *low/down* rather than the precise term *depressed*. Here, the vagueness may be persuasively significant (Potter 1996 p. 166), as it may elide between everyday unhappiness and psychopathology.

This has important implications for practice. Participants used a rather loose intuitive yardstick rather than any recognized diagnostic criteria such as the *Diagnostic and Statistical Manual* (American Psychiatric Association 1994) or the *International Classification of Diseases* (World Health Organization 1992) to assess the level of depression exhibited. Such practice may be detrimental to patients and highlights the fact that despite moves to characterize and classify the activities involved in nursing (Clark & Lang 1992) and encourage comprehensive documentation (Gruber & Gruber 1990, Allen 1994), no generally agreed rubric exists for expression in medico-nursing records. Some reform of this situation would be to train students in the acquisition of precise mental health nursing vocabulary.

There are also theoretical implications in the students being so glib about attributing emotional states and psychopathologies to the patient. Being presented with a person in this context immediately sets up for them an 'explanation slot' (Antaki 1994) which professionals typically fill with diagnoses, explanations and prognoses. Their use of lay terms like *low* or *down*, their use of modals, and the hasty diagnostic judgements make up a package which establishes which side of the boundary the patient falls. However, it also forms what Bhabha (1992) calls a 'productive ambivalence' — a way of thinking through the intersection of symptoms, psychiatric interventions and social mechanisms (Fuchs 1996). What the students write, then, fills the gap between textbook presentations of mental disorders and enables them to carry on future nursing activity. Moreover, studies of the words used to characterize patients' emotional problems (e.g. Cremnitier *et al.* 1995) show that diagnosis involves perceiving connections between sets of terms. French GPs in Cremnitier *et al.*'s study described depression in terms of insomnia, anxiety and fatigue. Thus our students are establishing 'diagnostic spaces' into which the patient's problem can unfold.

Lexical density

A measure of the style of a text can be obtained by looking at the density of lexical items or 'content words'. In our SR corpus of 5539 words the proportion of lexical items was 2253 and grammatical items was 3305, giving a lexical density of 40·5%. Ure (1969 p. 445, Halliday 1985 p. 62) found that most spoken texts had a density under 40% whereas most written texts had a higher lexical density. Thus, the lexical density of the nursing texts is midway between spoken and written texts. The tension between literate textbook language in medicine, 'real life clinical experience' (Levine 1989 p. 4), and the ineffability of much of what happens in nursing (Hays 1989 p. 203), may construct this peculiar position midway between oral and written culture.

Reported speech

Levine's (1989) interest in how nursing emerges from 'shared real life clinical experiences' sets the stage for a further legitimizing and evaluating device, that of 'reported speech', which as Caldas-Coulthard (1994 p. 297) notes, often involves authorial interference. The material in the videotape was reproduced and reported by the students who were also orienting to this reportage in a reflexive manner. For example:

> At the beginning of the interview, he said how low he was feeling, and how much he would like to end it all (though not in these words), and therefore came across as being almost suicidal.

This includes some self-consciousness about the reporting process. Nevertheless, re-wording the speech legitimizes the author's diagnosis and evaluation.

In the second extract below, the author selects items that are most important to her evaluation.

> He states he feels trapped and is only existing, not living… He states his job was getting him down and that he's 'always been a homely' person. He appears unreactive and expresses that he is unable to 'pull himself up'. He has a very negative view of life and himself.

Selection favours some items while discarding others in order to justify the decision. This is a legitimizing process which allows the author to manipulate facts whilst appearing faithful to the actual words of the patient. The students participated in this rhetoric of reality construction and anchored their inferences to the encounter between patient and professional.

Text structure

The nursing reports are structured according to a 'problem/solution sequence' (Winter 1986, 1994, Hoey 1994) which is so dominant that participants reverted to it despite being instructed to follow a solution/problem format. As Berg (1996) argues, the structure of the medical encounter often corresponds to the structure of the forms which have to be filled in, and the narrative of patients' problems. Understanding the pervasiveness of these structures of storytelling invites consideration of a great deal more about the narrative structures of care as a whole. Analysis of the text patterning is central to the study of genre and helps to locate the textual features and the 'tactical value' of a particular text.

Qualified nurses' texts: some comparisons

A more sceptical approach was immediately evident in the reports of qualified nurses whose more sophisticated and sensitive assessment drew attention to the limitations of the video recorded evidence. For example, one participant claimed it was 'difficult to judge self-care'. Another wrote: 'Normally I would consider eye contact, but the nature of the interview was such that this was impossible to assess'.

This scepticism led to a reluctance to make a concrete diagnosis. Whereas the student nurses insert modalizing terms the qualified nurses are more exact about the uncertainties. However, a good deal of their professional common sense remains intact. For example, the tacit assumption that self-care is something to be concerned about, or that eye contact, if it could be detected, might be a useful index of mood or self-image are not subject to the same reflexive scrutiny as the videotaped evidence.

Qualified and student participants were similar in that they both tended to report the client's own words and broadly agreed that he was depressed. However, qualified participants expressed less certainty about this. One qualified participant considered whether the client was depressed or attention seeking and gave options for treatment, including community input, once diagnosis was made. The emphasis among the graduates was either further assessment of the client prior to his hospitalization, or admission to hospital for assessment. One graduate insisted that any decision must be based on a full mental state examination of (a) physical symptoms of depression, (b) suicidal ideation, and (c) psychotic features. Another participant also emphasized the need for further assessment:

> Questions regarding suicidal ideation & intent were not directly asked. He possibly shows suicidal ideation, e.g. 'life is coming to an end', but makes no direct expressions of either ideation or intent. This would be a main area for assessment.

Thus the graduate nurses dealt with the limitations of this clinical vignette — they are aware of what was not said and are less bound in their commitment to a professional viewpoint. Student nurses took the vignette as a vehicle for displaying what they believe is expected of them — that they know how to judge a person's state of mind, which they do without awareness of any limits to what is presented in the vignette. On the other hand, those who have completed their training are able to adopt an analytical stance more aligned with the everyday scepticism which we might bring to partial or incomplete evidence. This raises the question of whether this more competent professional practice involves escaping the anxiety that bedevils student nurses trying to prove they have diagnostic ability.

Admittedly, the sample of texts by qualified nurses is small and therefore does not merit the extended analysis given to the students' texts. However, our comparison should draw attention to the potential of researching the lexical choices and reasoning strategies of nurses. Moreover, we can begin to see how these are refined as they change from novice to experienced users of the nursing register. Overall, despite our modest corpus of nursing reports, we hope to provoke some fundamental questioning of the role that language has in the socialization of nurses. We have provided an advertisement for a more systematic research approach to the uses of language in nurse training and practice.

CONCLUSIONS

Our conclusions should be understood in the context of a growing belief that nursing language should be addressed comprehensively in all forms of nurse training, and bear on the question of whether nurses are firing paper bullets at patients or merely letting off blanks. In this paper we have discussed some of the semantic inadequacies of the terminology used to describe patients which suggests a need for greater awareness and reflection upon the incarcerative potential of nursing language in general, not simply that used in mental health nursing. We would suggest that relevant nursing bodies need to develop training curricula to promote greater reflection on language use in the various nursing disciplines and establish protocols for improving descriptive accuracy, particularly in report making. Such an emphasis on textual management, of course, requires a much stronger body of research about nursing language than that which has emerged so far.

In our study we identify a number of features about mental health nursing language. We draw attention to the high incidence of lexical items such as *feel* and *need* in the reports compared to texts in general. This reflects, perhaps, humanistic or client-centred concerns, and contrasts with the more distant and scientific style one expects from medical discourse. However, it could reflect an 'orthopaedics of the soul' (Miller & Rose 1994), whereby therapeutic theory also regulates the clients by unfolding the spaces into which their distress can then be packaged.

The high incidence of 'intermediate modalities' as opposed to 'categorical modalities' which Fairclough (1989 p. 129) argues support 'a view of the world as transparent — as if it signalled its own meaning to any observer, without the need for interpretation and representation' suggests that participants were unable or unwilling to write definitively, giving opinions in a style which undermines their strength. In fact, we wish to argue that uncertainty might even be offering resistance to the more categorical style of medical language. Future investigation could explore further whether this modalization 'says nothing' (Levine 1989).

Another area of uncertainty and practical concern identified in the study involves the variation in adverbs and adjectives between different nurses' accounts. This might be expected concerning the diagnosis, but was more remarkable in describing the patient's physical appearance. Perhaps some effort in training nurses so that their observations converge would be desirable. In other disciplines based on observation and description, like botany, education ensures that students' descriptions correspond to the field's established standards. This does not necessarily mean that descriptions correspond with reality, but does ensure a consistent community of understanding amongst the observers.

The descriptive diversity even involved heterogeneity in the labelling of the subject, ranging from *man* to *gentleman*, and *patient* to *client*. One graduate nurse countered distance and anonymity by using a fictional name, 'Tom'. Such variety suggests that the participants are lacking in consensus about the status of those who need psychiatric care. The low use of the term *client* may well correspond to its ambivalent status in health care. The term tends to be associated with rhetorics of user empowerment. These form an uneasy bridge between traditional medical model orientations, and more radical, politicized strategies to prioritize the interests of the user. Perhaps this heterogeneity corresponds to the currently fragmented nature of the philosophy of mental health care. The structure of nursing culture is often seen as 'unknown territory' (Suominen *et al.* 1997). Perhaps this diversity might be reduced if there were a greater commonality in the 'ways of seeing' (Berger 1972) encouraged by training for nurses. Whether such cohesion is beneficial, of course, is another matter.

On the other hand there is some evidence for a cohesive philosophy of care if we look differently at the words used. The prevalent semantic sets in our lexical table (Table 1) highlight a strong structural and topical 'cohesion' (Halliday & Hasan 1976) to the reports which focus on the patient's cognition, emotion, motivation, social status and both the deficits and benefits of nursing interventions. This cohesion is part of the problem/solution text structure identified by Winter (1986, 1994) and Hoey (1994). Agreement between binomials and the wide use of reported speech again add to our sense that these reports are manufactured within tight generic rules on what we might call a language production line. This might equally apply to the more speech-like lexical density of the SR corpus, with its dialogical rather than monological style, a feature suited to the oral culture or conversational style of nursing which has been noted elsewhere (Fisher 1995). The democratization of health care can only benefit from nurses engaging in a full dialogue with clients and entering their life worlds (Mishler 1984).

In our analysis of reported speech we warned of the dangers of taking this technique for granted and of the ideological functions of selectivity. Participants' awareness of mediation and self-consciousness of their own status as analysts was generally low. Graduate nurses, however, were more sceptical in making their observations and recommendations. We would argue that reflexivity in analytical work is a valuable skill for nurses. This can build on the existing focus on reflection which has come to predominate nursing practice — indeed becoming reflective is already an important part of the socialization of new nurses (Attree *et al.* 1994). Attending to the basis on which we make our judgements might explain the diversity in our SR corpus. Whether the 'loaded weapon' (Bolinger 1980) of language is used to fire paper bullets or mere blanks, the mechanism must be understood.

This study has begun to describe and analyse mental health nursing language and raise awareness about its difficulties, uncertainties and conflicts. Nurses need to become aware of the power of language and become as cautious about it as they are about registering blood pressure. Language is where power is embedded and where the struggle for emancipation can occur (Fairclough 1989). Reform can only begin by describing and analysing that language. Critical linguistics helps guard against naive communication and imbalances of power. This approach must be backed by a willingness on the part of educators to build on these findings by bringing into training curricula a language component which is tailored to the widely established concerns regarding the generation of meaning in texts. Perhaps students can be helped to acquire a technical register which facilitates profes-

sionalism, but which does not incarcerate nurses along narrow or standardized lines of practice, nor incarcerates those for whom they care.

How does nursing language exert power and reveal its own power relations? We have not fully answered this question, but we have raised the alarm that nurses might be writing texts which damage in some way those they are caring for or which meticulously avoid certainty. This uncertainty at the level of microstructure contrasts with the coherence detected in other foci of research on occupational socialization. Models of care, for example, have been easily related to practice (Cutts 1993) and nurses' growing understanding of the limitations of health care as they become socialized (Day *et al.* 1995) have been subject to scrutiny, yet this apparent cohesion breaks down as we turn up the magnification to look at the linguistic structure in more detail.

What these reports suggest, however, is that nursing language is profoundly rooted in everyday language. This opposes the view in much previous research that a good deal of professional communication revolves around jargon, concepts and models which are not understood by patients (Hein *et al.* 1985). A popular image in accounts of health care is of professionals being socialized into an exclusive culture with a 'symbolic capital' of esoteric, medical language (Bourdieu 1977, Wodak 1996 p. 36). Yet we have found little in our own data to support this. Maybe the idea of a professional language is a form of wishful thinking on the part of nursing educationalists and those trying to promote nursing as a profession! It also presupposes that nursing has a self-evident professional identity which many contemporary commentators on the discipline have been at pains to point out is lacking (Taylor 1997, Fagermoen 1997, Suominen *et al.* 1997). Our results suggest that much nursing language is very ordinary indeed. Where technical terms appear, they are deployed with a lack of precision.

The growing interest in linguistic analysis in nursing may lead to the recognition that professional jargon forms only a proportion of the language used. Previous accounts of nurses' socialization which emphasized the acquisition of specialist language granted a status to professional jargon disproportionate to its actual usage. Our study suggests that mental health nursing language involves a care-focused use of everyday terms.

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