

Listening to Patients

A study of illness discourses, patient identities, and user involvement in contemporary psychiatric practice.

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Agnes Ringer

Listening to Patients

A Study of Illness Discourses, Patient
Identities, and User Involvement in
Contemporary Psychiatric Practice

Ph.D. dissertation
Graduate School in Lifelong Learning
Roskilde University, Denmark
2013

Agnes Ringer

Listening to Patients. A Study of Illness Discourses, Patient Identities, and User Involvement in Contemporary Psychiatric Practice

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Foreword

This PhD dissertation is a result of a three year study in the Graduate School in Lifelong Learning at Roskilde University. The research perspective of lifelong learning comprises learning through the whole life course in formal education, everyday life, work life, family life, civil society, etc. Thus research in lifelong learning calls for an interdisciplinary approach to learning as a subjective activity in a social context.

The Graduate School in Lifelong Learning was established in 1999 with support from the Danish Research Academy. Since the PhD-programme was established more than hundred students have achieved the PhD degree and presently around 60 students are enrolled. The Graduate School has an annual enrolment of 10-15 new doctoral students. It is an international research training programme. Academic everyday life comprises frequent visits by international guest professors and visits by foreign PhD students. Both students and supervisors are engaged in international research networks. Also, the Graduate School is part of a national network developing and coordinating educational activities for PhD students.

The Graduate School draws upon theoretical and methodological inspiration from traditions within the arts and humanities as well as the social sciences. Graduate School training addresses issues traditionally ignored by discipline-oriented research and professional knowledge. It particularly focuses on learning as the subjective mediation of objective, societal and cultural processes. Research in Lifelong Learning encompasses a variety of subjects and is equally broad in the perspectives it takes. The topics of the PhD dissertations are often quite far from what is usually associated with pedagogy, but help to co-establish an emerging critical and historically located important area of research. This often demands theoretical and methodological innovation. At the same time the programme aims to establish connections between existing traditions in pedagogical research and associated disciplines. Methodologically the graduate school concentrates on qualitative methods and interpretive methodology. Within a wide scope each project may choose and adapt quite different methods to the specific research problem.

A PhD dissertation marks the end of an academic apprenticeship. It proves that the author has been “conducting an independent research project under supervision” as stated in the “Ministerial Order on the PhD Course of Study and on the PhD Degree”. It is the culmination of the process that is

published here. PhD dissertations are however also part of the development and forming of new areas of research. PhD dissertations are necessary in the continuous creation of new knowledge and reading this dissertation assures that this process is well taken care of.

This thesis at hand presents an interesting, ethnographic study of interactions between professionals and patients in Danish psychiatric institutions. The main aim of the thesis is to explore the limitations and possibilities for user involvement in daily psychiatric practices in Danish Mental Health institutions. The study was launched as part of the project “User-led Psychiatry” in Region Zealand with a particular interest in the “the interplay between language, values and user involvement in a psychiatric context”. The thesis is based on an ethnographic field study of a closed inpatient ward and an outpatient clinic in Region Zealand in Denmark in 2011. The study lasted three months and involved participant observation as well as 13 interviews with patients and 11 interviews with different professionals.

The study employs a social constructivist approach to investigate how discourses unfold among professionals and patients in the daily psychiatric practices. From a Foucauldian perspective, the language used in mental health services is regarded as a type of identity work on patients situated in a broader institutional context. The interest is to study the relation between broader institutional discourses and the local reactions to them in the day-to-day interactions. The results of the analysis are presented in three articles.

The thesis deserves to be read by everyone with an interest in psychiatry and people with an interest in the idea of user-involvement. The thesis is well-structured and very well-written and it has significant academic impact.

Theoretically it discusses the difficulties of working with the concept of “situated knowledge” (Donna Haraway). It discusses the risk of privileging the patients’ knowledge as the only “subjugated” knowledge. Ringer examines the difficulties of balancing a position that acknowledges the misery many patients experience on the one hand, and on the other hand one that does not deny the exercise of power in psychiatric treatment. Ringer intends to move beyond a critical deconstruction of dominant discourses of mental health in order to explore how these are adopted and challenged in interactions. She uses positioning theory to have a focus on the experiencing, embodied subject, who is not reduced to a strategic, rational discourse-user.

Methodologically the thesis contributes to the discussion of—and demonstrates— how the self-reflexive work of the researcher can be part of the analysis of field experiences and can function as a source of answering the

research question. Article one discusses the researcher's positioning during the fieldwork as sources of data, and it demonstrates how the positioning processes were indicative of discursive norms in the field. It argues that the categories of "patient" and "professional" and the binary pair of "pathology" and "normality" worked as structuring norms in the researchers' interactions with patients and professionals. The problems associated with negotiating a position from which to reach both groups are seen as indicative of norms that separate professionals from patients, and as indicative of the powerful biomedical discourse of pathology. The article concludes that if patients are to adapt to the discursive norms of the field in order to be regarded as competent, then the question of how to involve patients is very complicated. Furthermore, if the professionals are to adapt to the norms in order to be regarded as "professional", user involvement does not only depend on the professionals' willingness to attend to the patients' wishes.

The results of the thesis can contribute to ongoing discussion in the field about the barriers for implementing user-involvement, which are not reduced to questions about the professionals' willingness to listen to the patients. In article two ("Hell no, they'll think you are mad as a hatter") the discursive norms in the field are elaborated. Three distinctive institutional discourses are identified; the "instability" discourse, the discourse of the "really ill", and the discourse of "lack of insight". These discourses are derived both from interactions between patients and professionals, and from interviews with patients, and thus have a particular focus on the embodied experiences of patients, which may become silenced in the meetings with the professionals. It is shown that for patients these norms bring to the foreground particular ways of visualizing mental illness, rendering other expressions of distress problematic or inauthentic. Patients, who are not able to decode the discursive norms, and act according to them, risk having their views dismissed. The paper concludes that if user involvement is to be taken seriously, it would imply a reflexive attention to the discursive norms and their implications. Thus, the thesis provides detailed insight in particular norms of the field, which are generated by the intensive fieldwork. These norms work as part of the taken-for-granted knowledge in the field and they are very difficult to reconcile with the political intention of increased user-involvement.

In the third article, the identification of barriers and possibilities are elaborated, with a particular focus on incidents in which professionals try to involve patients. The third article ("I would like to retain your compulsory treatment, is that alright with you?") discusses the professionals' navigation in the contradictory field of ethical ideals about equality and listening to the pa-

tients, and technical discourses on expert knowledge. It demonstrates how involving the patients' perspectives entails a complex balancing act of the professionals, which often involves a subtle re-negotiation of discursive norms, often in the form of "making exceptions". It concludes that if user involvement initiatives are to extend beyond tokenism, mental health professionals need to be supported in their endeavors to involve patients by a system which allows for complex definitions of mental distress and less rigid standards for quality and efficiency. Thereby, the thesis contributes to a critical discussion about the consequences of neoliberal regulation.

Finally the thesis provides an important discussion of measures that must be undertaken if user-involvement is to be taken seriously. It concludes that if the democratic potential of user involvement is to unfold, the truth of psychiatric knowledge has to be revisited and the psychiatric system has to embrace diverse definitions of mental distress. Also the patients must to be involved in the planning and organization of psychiatric treatment, if user involvement should not be reduced to consumerist notions of choice.

Annegrethe Abrenkiel

Associate Professor

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Til M. der drømte om at have vinger på ryggen, og som endelig havde forstået at den lille pige ikke var ”forkert”.

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For M. who dreamt about having wings on her back, and who finally learnt that the little girl was never “wrong”.

And

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Chapter 1: Introduction

A major feature of the policy and practice of mental health care in recent decades has been to work towards a more active involvement of patients and their perspectives. This initiative is often called user involvement, and broadly defined it aims to place the patient, her wishes and needs in the center of attention. However, despite the recognition of the importance of user involvement among policymakers, patients and professionals (Anthony & Crawford, 2000; Bowl, 1996), there is an increasing amount of research which calls into question the extent to which patients and their perspectives are actually being involved in the delivery and planning of mental health services (Bowl, 1996; S. M. Hodge, 2009; Pilgrim & Waldron, 1998; Roberts, 2010).

Qualitative researchers have specifically suggested that psychiatric language, with its restrictive definitions of the patients' identities and problems, may create barriers to involving patients' perspectives (Borg, Karlsson, & Kim, 2009; Roberts, 2010; Stickley, 2006). However, many of the discussions on psychiatric discourse and service user involvement have been theoretical. This thesis takes up the discussions on language in psychiatry and its implications for patients, but presents an empirical account of how discourses unfold among mental health professionals and patients in daily psychiatric practices. Specifically, I explore how discourses that are drawn on in two mental health institutions in Denmark create specific norms, definitions of patienthood and mental illness - with implications for the patients' self-understandings and for their active involvement in the treatment.

The thesis is based on an ethnographic study of a closed inpatient ward and an outpatient clinic carried out in Region Zealand in Denmark in 2011. The study lasted three months and involved participant observation as well as 13 interviews with patients and 11 with professionals. Drawing on the work of Michel Foucault and psychological theory informed by his work, I explore the ways in which different discourses are drawn on, appropriated, adjusted and contested in meetings between patients and professionals. Particularly, I examine the implications of these negotiations for the practice of service user

involvement, i.e. for involving patients and their perspectives in the treatment.

When approaching psychiatric research and practice, the researcher finds a contradictory and polarized field. As the medical anthropologist Lorna Rhodes (1995:4) has pointed out, there have traditionally been two very different ways of studying psychiatry. One way centers on the patients it treats – it focuses on defining their problems (framed in different ways: biological, psychodynamic, cognitive, systemic etc.), how they can be treated and how they affect the professionals who treat them. This is the underlying perspective in much of the literature produced by psychiatry itself, for example studies that aim at providing an evidence base for treatment by evaluating the efficacy of interventions. Such literature treats many of the problems in psychiatric institutions (e.g. the negativity professionals may feel toward patients) as elements which interfere with psychiatry's basic function of helping and treating patients (*ibid.*).

The other way of studying psychiatry, often considered irreconcilable with the first, views psychiatry as a place of social control, whose function is to normalize deviance and preserve the social order (Rhodes, 1995:5). From this perspective, the role of the mental health services is to control and regulate people who do not “fit in” with the rest of society. It is this critical perspective on psychiatry that makes the mental health field a rather special field, quite unique in the context of medical specialties.

Both perspectives have been valuable for my work in the thesis. The first perspective has encouraged me to remember the well-meaning intentions of psychiatric professionals to help and provide care for people in need. It has also prompted me to not diminish the patients' experiences of distress - and the human existential need for establishing caring and supportive relationships. The second perspective has been equally important; it has reminded me of the importance of the broader social and historical contexts which contribute to shaping the identities of those rendered psychiatric patients. It has helped me to situate the practices of mental health professionals and the experiences of the patients in a wider institutional and cultural landscape.

However, the longer I have spent working on the thesis - writing, reading, doing interviews and observations in psychiatric settings - the more have I realized that both perspectives fall short of grasping the complexities and

contradictions that patients and professionals are faced with every day. There is not *one* psychiatry, but many *psychiatries*: a plethora of local understandings and tensions, varying not only from setting to setting, but from situation to situation, professional to professional and patient to patient. With this in mind, I aim to provide an account of psychiatric practice which is open to complexities and contradictions. Rather than reducing these to one single representation, I will approach the field from different angles – and strive to acknowledge some of the dilemmas so omnipresent in psychiatry.

My assumption throughout the thesis is that psychiatric language, knowledge and practice are not neutral or “objective” reflections of reality, but constitute a particular set of knowledge, upheld and made influential by institutions like mental health facilities and psychiatric research. In recent years, psychiatric knowledge and practice have been subject to massive challenges and criticisms - leading some to suggest that today’s psychiatry is experiencing a “crisis of legitimacy” (cf. Bracken et al., 2012). While it is certainly the case that the current policy of user involvement in mental health services is also associated with other forces, I suggest that the wish to involve patients and to reform psychiatry must also be seen in the light of these indictments. The wish to involve patients and their perspectives in mental health care may be regarded as a way for psychiatry to accommodate to some of the arguments of its critics. Before I go on to describe the purpose and aims of this study in more detail, I will therefore outline some of the criticism and challenges to psychiatry that have been occurring in recent years.

The crisis in psychiatry

In 1997 the world-leading medical journal, *The Lancet*, published an editorial entitled “The Crisis in Psychiatry” (Editorial, 1997). In it, the authors argued that psychiatry was facing a crisis of previously unseen proportions; the traditional rigid disease and diagnosis models had little to offer to the ever-increasing amount of people suffering from various forms of distress in an increasingly globalized world. The editorial argued that psychiatry was in desperate need to renew its treatment models and assumptions - and unless this were to happen the future of psychiatry appeared inescapably bleak. The editorial triggered a series of responses from researchers and psychiatrists. Some lent support to the basic premises of the editorial (e.g. Venegas, 1997) while others disputed the presence of a large-scale crisis, arguing that the editorial

painted a too pessimistic picture (Jones & Craddock, 1997; Pincus, 1997). However, few could deny that in one way or another, psychiatric treatment models, research and diagnostic classifications seemed to rest on somewhat unsafe grounds.

Some sixteen years later, in 2013, the notion that psychiatry is in trouble appears even more evident. The initial enthusiasm that accompanied technological advancements in psychopharmacology and neurosciences in the 1980's and 1990's has proven deceptive. Some prominent psychiatric researchers even go as far as arguing that despite decades of economic investments and hard labor:

“... research into biological mechanisms of mental and behavioral responses has failed to deliver anything of value to clinical psychiatrists and is very unlikely to do so in the future” (Kingdon & Young, 2007: 286).

There is increasingly more evidence from treatment outcome studies that the effects of psychopharmacological interventions are unimpressive at best (Bracken et al., 2012; Kleinman, 2012; Moncrieff & Cohen, 2009; Moncrieff, 2008; Whitaker, 2005). For instance, studies have indicated that the antidepressants Prozac and later SSRI's - which were launched in the 1990's as “smart drugs” that would fundamentally transform psychopharmacology - have little more effect than placebo (Barbui, Furukawa, & Cipriani, 2007; Kirsch et al., 2008; Kirsch, Moore, Scoboria, & Nicholls, 2002; Moncrieff & Kirsch, 2005). Further casting doubt on the legitimacy of western treatment models, a large-scale WHO-study conducted in the early 1990's revealed that the long-term outcomes for patients with schizophrenia in high-income countries, despite these countries' costly and technologically advanced mental health services, were significantly poorer than in developing countries (Jablensky et al., 1992; Jablensky & Sartorius, 2008).¹

¹ The study, which was a 15 year follow-up study, replicated and confirmed the findings of earlier WHO studies conducted in 1969 and in 1978, but made use of a more stringent and standardized methodology. The reasons for why people diagnosed with schizophrenia are so much better off in developing countries remain speculative. Many have attributed this to cultural differences, suggesting that developing countries may have stronger social and family ties and less stigma associated with mental illness (Bentall, 2003; S Estroff, 1985; Jablensky & Sartorius, 2008). An alternative (and rather unsettling) interpretation has been put forward by the American science journalist Robert Whitaker (2010), who noted an association between low levels of usage of antipsychotic medication in the developing countries in the study and their good rates for recovery. Whitaker suggests that the WHO studies provide evidence that in coun-

The development of the new American *Diagnostic and Statistical Manual of Mental Disorders*, the DSM-5, which was published this spring (2013), started with a grand ambition to provide a “paradigm shift” based on the identification of biological markers of mental illness (Frances, 2009), but turned out to be a protracted and controversial affair – revealing the contested nature of psychiatric classifications. The psychiatrist Allen Frances, who chaired the taskforce of the previous diagnostic manual, the DSM-IV, has openly opposed the DSM-5, claiming that it medicalizes normality and may result in an “epidemic of false positives”, with excessive harmful treatments becoming ubiquitous (Frances, 2009:391, 2012). Other leading psychiatrists have called the DSM the “death of phenomenology”(Andreasen, 2007), arguing that the: “DSM has had a dehumanizing impact on the practice of psychiatry”(p. 111) and that the DSM “discourages clinicians from getting to know the patient as an individual person” (ibid.) They argue that the diagnostic tools have perhaps provided a reliable nomenclature for research, but an invalid and wrong one: the diagnoses do not reflect what they should. Still other psychiatric researchers, such as Kendell & Jablensky (2003), have argued that psychiatric diagnoses may potentially be clinically useful, but are not at all scientifically valid.

Paralleling the internal struggles among psychiatric researchers, we witness a rapid expansion of service-user organizations, demanding changes and reforms in psychiatry. Some of these organizations take a political stance towards the bedrock of psychiatry – the concept of mental illness - and establish alternative treatments and support groups that aim at making patients independent of psychiatric services. For example, the *Hearing Voices Network/Intervoice*, which is the largest international network for service users, aims to help people redefine their experiences of hearing voices in ways that do not reduce their status to that of the victimized mentally ill (Blackman, 2001; Fee, 2000; Parker et al., 1995). Service user channels are becoming more political, globalized and collectivized and they are gradually more visible in the form of books, conferences and magazine articles (Crossley & Crossley, 2001: 1477; Singla, in press).

tries where patients are not regularly maintained on antipsychotic medication, the majority recovers and does well within fifteen years. Thus, he argues, long-term usage of antipsychotic medication damages neurotransmitter function in the brain, which prevents the person from recovering.

At the same time as we witness this “loss of faith” in many aspects of the project of psychiatry, the amount of people who are using or may potentially use psychiatric services are growing at a previously unanticipated rate. In 2001 the World Health Organization published the report *Mental Health: New understanding, new hope* (WHO, 2001) to draw attention to the societal challenges posed by psychiatric disorders globally. The report estimated that more than 24% of all people worldwide will suffer from a mental disorder at some point in their life; it reported that depression in 2020 will become one of the largest financial, social and human burdens in advanced societies. In the USA the percentage of the population said to be mentally ill has tripled since 1955, with one in four North Americans said to suffer some kind of mental disorder within a 12-month period (Kessler, Chiu, Demler, & Walters, 2005). Denmark does not deviate from this general tendency. A report published by OECD in 2013 (OECD, 2013) estimated that every fifth person of working age in Denmark suffers from psychiatric problems - a number equivalent to the OECD average. The report estimated that psychiatric problems cost approximately 45 billion DKK yearly in lost productivity, health service expenses and social benefits. A report by *Danske Regioner* estimated that every second Danish family will at some point in their life be in touch with the mental health services (Danske Regioner, 2009: 1). According to the same report, the amount of patients treated in the mental health services in Denmark has doubled between the years 1999 to 2009. Additionally, the report claims many people walk around with “undiagnosed” and “untreated” disorders – and it states as one of its goals for psychiatry to be accessible to everyone. While there are many potential explanations for why the number of people with a presumed mental illness is growing at such a rate, many researchers (e.g. Brinkmann, 2010; Rose, 2010) have pointed towards a general “psychiatrization” or pathologization of the social world - in which an increasing number of human conditions, sorrows and miseries are captured under the headings of an expanding bio-medical diagnostic system. Thus, they argue, the threshold for when people may be defined or may define themselves as suitable for psychiatric treatment has been lowered considerably.

While critical discussions on psychiatry are occurring on a global scale, in Denmark some of the developments are still modest in scope. However, here also we see some challenges to traditional psychiatry (cf. Singla, in press). Apart from The Hearing Voices Network, which nowadays has a branch in Denmark with self-help groups and political lobbying around the country, user organizations such as LAP, *Landsforening for Tidligere og Nuværende Psyk-*

iattribrugere established in 1999, have become more visible in their work for decisive influence on the practices and delivery of mental health services (www.lap.dk). The Danish mental health services have also been in the firing line for scandals and heated media debates in recent years. Among other things, newspapers have exposed practices of heavy overmedication in hospitals in the area of the capital city, greatly exceeding the guidelines of the Danish Health and Medicines Authority (Dam Nielsen, 2012; Drachmann, 2012), a range of sudden deaths among psychiatric patients due to overmedication (Schmidt, 2013b) and excessive use of coercion and methods of restraint (Schmidt, 2009, 2013a). This has sparked debates and controversies with, among others, the former Prime Minister, Poul Nyrup Rasmussen, writing a feature for the newspaper *Politiken* (Simonsen & Nyrup Rasmussen, 2012). In the feature he called for a thorough inspection of the “culture of psychiatry”, claiming that contemporary psychiatry is characterized by coercion, overmedication and a lack of respect for human dignity. As a response to what he perceived to be development gone awry, the former prime minister established *Det Sociale Netværk* (The Social Network), a network consisting of user organizations and NGO’s aimed at promoting change and democratization in psychiatry.

In the meantime, and partly to accommodate the criticisms, psychiatric policy, practice and research have co-opted some of the terms of its critics and the service user movement. Terms such as “recovery”, “empowerment”, “partnership”, “participation”, “user-led services” and “service user involvement” have become a key part of policy making in the mental health arena. Currently, especially the idea of service-user involvement is playing an increasing part in the policy and practice of western psychiatry (Stickley, 2006). In Denmark, carer and user participation and involvement is a frequent theme in mental health planning and organization, and is now inscribed in legislative documents (Psykiatrien Region Sjælland, 2010a; Region Sjælland Psykiatri, 2010).

Criticisms of psychiatry are not the only source of the increase of ideas of involving patients in the treatment. The idea of user involvement also has roots in consumerist market forces that have shaped the public sector in general in recent decades. These are part of a neoliberal ideal of re-structuring the welfare state, a trend sometimes called New Public Management. The movement has entailed the processes of an increased managerialism and the creation of quasi-markets (Pilgrim & Waldron, 1998) in the public sector, which place a

value on consumer feedback and satisfaction to increase efficiency. In the mental health services, the development has involved a discursive shift of accountability to “consumers”, which emphasizes free choice - while rarely questioning diagnostic accounts of mental illness (Speed, 2011). Hence, the true commitment of policymakers and practitioners to involving patients’ perspectives, and the extent to which service user involvement may actually be empowering for patients, has been questioned (Pilgrim, 2005; Roberts, 2010; Stickley, 2006). Some (e.g. Speed, 2011) have suggested that rather than psychiatric patients or professionals, the key beneficiary of the consumerist trend has been, and continues to be, the state.

These developments set the scene for this thesis. Psychiatry is expanding and an increasing amount of people are entering the range of psychiatry’s interventions. At the same time, there is growing attention, internally and externally to psychiatry, to problematic aspects and traditions in psychiatric practice - as well as to an increasing commodification of mental health care. In the area of tension between these forces, it becomes relevant to take a closer look at psychiatric practice and the idea of user involvement. How is user involvement practiced and understood in a psychiatric context? What is its relation to the assumptions which form the base of psychiatry? And what may be the barriers and possibilities for democratizing mental health care by involving patients in the planning and delivery of services?

One of the regions in Denmark, which has taken the notion of user involvement to heart, is Region Zealand. A few years ago, in 2009, the project “User-led Psychiatry” (*Brugerstyret Psykiatri*) was launched in the region. The project involved a number of local workshops, theme-days and other dialogue-based and educational initiatives to promote working towards the active involvement of patients. User-led Psychiatry took the initiative to launch a study on “the interplay between language, values and user involvement in a psychiatric context” (Psykiatrien Region Sjælland og Forskerskolen i Livslang Læring, 2010). And so the idea of this PhD-study was born, which was developed in cooperation with the Department of Psychology and Educational Studies at Roskilde University. When I started working on the project, the terms language and values in the original project announcement were developed into an inquiry into discourses, discursive norms and patient identities. In the next section, I discuss why it is relevant to study discourses, identities and user involvement in the mental health services.

Why study discourse, identities and user involvement?

My interest in language in psychiatric practice is based on a Foucauldian perspective on discourses and subjectivity. From this perspective, the practices and language used in the mental health services may be regarded as a type of “identity work” on patients, aimed at shaping and changing the patients’ identities. For instance, giving a psychiatric diagnosis may be seen as an invitation for a person to enter a medicalized social category, and thus to work on his or her identity and shape it according to the understandings prevailing in the institution (Roberts, 2005). Other interventions, such as psychoeducation, in which patients are taught about their diagnosis, medication which alters the person’s thoughts and feelings, as well as psychotherapy, all aim at shaping and forming the patients’ “inner self”, or identity. Because the function of the mental health services’ is to work on patients’ identities in different ways, this opens up questions such as: what types of identities are being constructed within the mental health services? How are these identities constructed? - And what are the consequences of these constructions?

I suggest that there is an intimate relationship between discourses, practices and service user involvement, in that different discourses drawn on in patient-professional meetings offer a range of identities to patients, which each implies specific possibilities of action for them. The question of whether patients are involved in the treatment therefore essentially becomes a question of how the particular psychiatric patient is defined – or who she or he is allowed to “become” (Holen, 2011) in the specific contexts of psychiatry. Stated bluntly, there are significant differences in defining the patient as a victim of a brain disorder (traditional biomedical discourse) and defining the patient as a discerning consumer who chooses freely among service providers (consumerist discourse) (Holen, 2011). My assumption, then, is that service user involvement should be studied by exploring the discourses that attempt to define who the patient is and what her problems are.

The discourse analysts Linda Wood and Rolf Kroger (2000:101) have argued that a distinction between what they call “agent” and “patient” is fundamental in all discourse. An agent is someone who is seen to make choices, orient to rules and can be responsible for their actions. A patient, on the other hand is someone who is perceived to suffer the consequences of either external or internal forces. This distinction, according to Wood and Kroger, is central to

all accounts of human action, both when talking about oneself and when talking about others. From a discursive viewpoint, this way of seeing people is not a claim about whether they actually are one or the other. However, naming and thinking of someone as an agent versus a patient inevitably has consequences for that person. With this in mind, the wish to promote user involvement in mental health care may be seen as a shift in mental health policy to attempt to position users of psychiatry more as agents than as patients.

At the same time the notion of service user involvement is intimately tied to another discourse which has increasingly gained footing in the public sector since the 1980's, namely the discourse of consumerism (Pilgrim, 2005). This discourse increasingly sees mental health care as delivering a service to a consumer. Health care is seen as a commodity which should be standardized and schematized to ensure the most time and cost efficient services. In this context, attempts to position patients as more actively involved are often translated to a position as free consumers on a market of mental health care (Pilgrim & Waldron, 1998). The definition of the patient as consumer conceptualizes the patient as a whole person with needs and wishes beyond those from a diagnostic viewpoint (Rogers & Pilgrim, 2010). However, consumerism is based on an assumption of voluntary partnerships, in which consumers can take or leave what is offered (Pilgrim, 2005). It has been noted that when applied to the mental health services, where involuntary detention and other practices of coercion are relatively commonplace, the consumerist logic fits rather poorly (Rogers & Pilgrim, 2010).

In Denmark, the discourse of service user involvement is intertwined with structural changes in the public sector in general, particularly a neo-liberal motion towards efficiency, evidence-based practice and standardization. Thus, for instance, we read in the booklet on core values of the mental health services in Region Zealand: "There is no mismatch between evidence-based practice and [user involvement], as the point of departure is that the patient is offered evidence based treatment options that the person concerned can choose to accept with guidance from the provider staff" (Region Sjælland Psykiatri, 2010:10, my translation). The statement constructs the patient-professional relationship as an equal give-and-take collaboration among partners. However, it seems to forget that in the meeting between patients and psychiatry, there emerge specific power relations, issues of complex dependencies, struggles on definitions of mental health problems - and that a substantial amount of psychiatric patients are being treated involuntarily.

In this way, the concept of service user involvement seems double-sided. On the one hand it may be an orchestrated move towards increasingly placing responsibility on the patient (and hence towards cutting public expenses) - but on the other, it may potentially open up for increased patient participation and a questioning of powerful discourses in mental health practice. This double potential has been noticed by others (e.g. Beresford, 2002) who note that user involvement may involve both a progressive and positive development as well as have a regressive potential. It has been suggested that, although the current model of user involvement is not straightforward, a more inclusive stance towards users' views may potentially allow for reforms in the mental health system (Borg et al., 2009; Tait & Lester, 2005). In this sense, user involvement may lead to the willingness to increasingly accept psychiatric patients' statements, views and understandings as legitimate. However, as Stickley (2006) has pointed out, insofar as patients are expected to adopt the prevailing understandings of the institution while they are being involved, then service user involvement may only serve to perpetuate and reinforce the existing power relations.

In the thesis, I am therefore particularly interested in user involvement as the possibility of allowing for the inclusion of patients' perspectives, also when these diverge from the prevailing institutional understandings. Such an approach to service user involvement sees it as possibly opening up for a more inclusive stance, in which alternative subject positions and discourses are allowed access to legitimate participation.

Research questions

Based on the discussions above, the research question of the thesis is as follows:

How are identities as psychiatric patients constituted discursively in the contemporary mental health services? What are the implications for involving patients' perspectives in the treatment?

These questions are answered through three articles, each one of which focuses on a specific topic in relation to the research question, and explores a number of related sub-questions.

In the first article I approach the topic by applying a self-reflexive methodological frame. I analyze the methodological dilemmas I encountered during the fieldwork, as sources of data which provided clues on discourses and positions for patients. The sub-questions asked in the article are:

- What processes of positioning became available for the researcher during the fieldwork?
- How can the researcher positioning processes be interpreted in terms of the discourses and norms that shape patient positioning?
- What might be the implications of this for involving patients' perspectives in the treatment?

The second article approaches the research question by exploring constructions of mental distress that were present in the settings and their implications for patients. The sub-questions asked in the article are:

- How are the various forms of distress that the patients experience defined and understood in terms of mental illness?
- Which discourses on mental illness are drawn on in meetings between patients and professionals?
- What might be the implications of this for patients and for involving their perspectives in the treatment?

While the previous two articles focus specifically on barriers for user involvement, the third article is concerned with both constraints and possibilities for involving patients in the treatment. The sub-questions asked in the article are:

- What possibilities for involving patients' perspectives are mapped out by the dominant discourses in mental health care?
- When and how does it become possible for mental health professionals to involve patients' perspectives?
- What might be the implications for mental health practice?

My approach to the research question and choice to explore it from different positions is based on an understanding of all knowledge as situated (Haraway, 1988) (cf. Chapter 2). From the standpoint of situated knowledges, all knowledge is seen as "from somewhere", from a certain partial perspective, and can never be free-floating or present a view "from above". This requires the researcher to constantly be aware of her position and relationship to the researched. In the thesis this epistemological approach materializes itself in three "angles" that I have chosen to pursue in the articles. The first article approaches the research questions from the angle of the researcher and inquires about processes of researcher positioning. The second article on illness

discourses approaches the research question from the angle of patients – and asks about their experiences in the mental health services. The third article approaches the research question from the angle of mental health professionals – and looks at their practices and experiences (cf. Chapter 4).

When I call these *angles* and not “perspectives”, the intention is to make explicit that these “angles” are my own constructs which developed during the reading of data; they do not as such represent directly the experiences of neither patients nor professionals. As long as the researcher conducts the analysis, she will have the monopoly of interpretation. My aim with reading the material from different angles is to create a nuanced account that attempts to analyze psychiatric practice from different positions, rather than to rely on the first level of interpretation.

My wish throughout the thesis is to develop a perspective on language, patient identities and service user involvement, which may encourage professionals and researchers to reflect on their practices and question taken for granted assumptions. In this way I will open up the exploration of the “very groundwork of psychiatry” (Barrett, 1996:13). This perspective leads to an inquiry into matters that may seem, to clinical psychiatry and perhaps to professionals, hardly worth asking about, because they may appear to be so ordinary, so natural, and self-evident (ibid.). Particularly, questions pertaining psychiatric knowledge and involving patients’ perspectives work as a structuring thread throughout the three articles of the analysis. In each article I expand on and develop new understandings of the challenges and possibilities for involving patients’ perspectives in mental health care. In the final discussion in the conclusion I recapitulate the main findings from the three articles and discuss how together they relate to my research questions.

Personal motivation

My personal interest in language and therapeutic practices stems from my education and therapeutic work as a psychologist. Throughout my education and work I have been attuned to the ability of language and communication in structuring human experiences and senses of self. My particular interest in psychiatric language, psychiatric categories and the experiences of psychiatric patients started when I was writing my Master’s thesis in psychology at Copenhagen University. In the thesis, my colleagues and I interviewed patients

diagnosed with borderline personality disorder on their experiences of participating in a psychiatric day-center treatment. The thesis focused particularly on the patients' experiences of integrative psychotherapy and was theoretically informed by phenomenological approaches - and so the thesis did not place much emphasis on language and its effects. However, in the interviews I noticed that our informants continuously made use of psychiatric vocabulary in defining their experiences. Some defined themselves as "mentally ill", others talked about themselves as "borderline", "depressed" or "social phobic"; yet others discussed their lacking skills in "mentalization", "emotion regulation" and their "biological vulnerability for psychopathology". All of these terms belonged to a psychiatric professional world, but seemed to have been appropriated and adopted by my informants in their processes of making sense of themselves. Because the Master's thesis did not specifically focus on discourses and psychiatric categories, at the time, we did not inquire into these terms more closely. However, the informants ways of describing themselves and their difficulties made me reflect on the question of language, identity and psychiatric knowledge. What happens to a person when she starts using psychiatric terminology about herself? Which assumptions about identity, mental health and the world are inherent in the psychiatric categories? And what if the psychiatric categories do not make sense?

I have had a wish to explore these questions further ever since. When I therefore saw the announcement for a PhD position which focused on language and psychiatry, I quickly outlined a research proposal. And so I embarked on a process which would last three years and would lead me to question many of my earlier assumptions. It would also open my eyes to the complexity of psychiatric treatment and practice - and to the importance of reflexivity and critical inquiry.

The background and process of the thesis

The initiators of this PhD-study were the management of Region Zealand Psychiatry in Denmark. They wished to promote a patient-centered approach and improve the active involvement of patients in the treatment. They were interested in the ability of the language used in communication with patients to either restrict or promote involving patients in the treatment. Moreover, Region Zealand had been working with service user involvement long before my official employment. In March 2008, the move for a more active in-

involvement of patients in their treatment was compiled in *Region Zealand's Plan for Psychiatry* (Region Sjælland Psykiatri, 2010) which is the document outlining the general directions, aims and visions of the Region. In 2009, the Region launched the project "User-led Psychiatry" (Brugerstyret Psykiatri), with the aim of implementing the values outlined in the Plan for Psychiatry. The values in the Plan for Psychiatry were formulated broadly, but some of the main values were defined as: an interdisciplinary approach to mental illness incorporating biological, psychological and social approaches; evidence-based practice; "decisive influence" (p.9) of patients on the treatment; involvement of relatives and carers; a focus on inter-human relations; respect for the individual, her or his resources and autonomy; standardized treatment with a focus on the individual; least possible coercion; and an integrated and coherent treatment (Region Sjælland Psykiatri, 2010; 9-10).

The management forum in psychiatry became the steering group for the project User-led Psychiatry. A so called *Ambassador group* was established; each district and facility appointed an "ambassador" who was to promote User-led Psychiatry. The ambassadors met one another at regular intervals to discuss the developments and how to proceed in order to implement User-led Psychiatry. The ambassador group's tasks were to create a dialogue about the values of psychiatry, to develop a tool to maintain the dialogue and to help local managements in planning and going through with local dialogue (Psykiatrien Region Sjælland, 2012). The ambassadors organized a large-scale theme day for all employees of the region on the values of the mental health services in September 2010, in which 300 professionals participated. The ambassador group also developed a board game called "the dilemma game", consisting of cases and dilemmatic situations which were aimed at encouraging collaborative reflexivity among professionals. Many districts additionally organized local workshop days during which the dilemma game was played and presentations and discussions on service user involvement took place. The developments of the project were finally described in a report which was published in 2012 (Psykiatrien Region Sjælland, 2012). After the three year project ended, a center for User-Led Psychiatry was established, with the task of developing the work outline for increased involvement of patients and carers.

Another related task of User-led Psychiatry was to initiate a study of "how values are expressed through language in practice" (Psykiatrien Region Sjælland, 2010a). This study developed into a PhD project, organized in re-

search collaboration between the mental health services of Region Zealand and the Department of Psychology and Educational Studies at Roskilde University. The co-operation between the two institutions was new and somewhat experimental. While the mental health services of Region Zealand and the Psychiatric Research Unit have primarily been engaged in traditional quantitative clinical research, the Department of Psychology and Educational Studies is primarily engaged in qualitative, critical social research.

In September 2010 I was employed to carry out the study. I had not previously had any connection to Roskilde University, nor had I worked in the mental health services, but my background as a psychologist and my long standing interest in critical and discursive perspectives served to fulfill the perhaps somewhat different expectations of both organizations. My PhD scholarship was financed by the management and District East in Region Zealand and I was enrolled in the Research School of Lifelong Learning at Roskilde University. I received desk space both at Roskilde University and in the Psychiatric Research Unit in Region Zealand. A supervisor from each setting was appointed, and I was greatly encouraged to find a way to bridge the differences between the two research traditions and make the study relevant and valuable for both organizations.

About half a year into the study, an advisory group for the PhD study was established, consisting of members from the psychiatric board of directors in Region Zealand, as well as chief physicians and head nurses from the districts involved in the study. Other members were stakeholders who had been key people in the project User-led Psychiatry. Approximately every half year I held meetings with the advisory group during which I presented the new developments of the study and engaged in empirical and theoretical discussions. In the beginning of the PhD process I also attended the meetings of the ambassador group for User-led Psychiatry.

As I started working on the thesis and immersed myself into the theoretical framework, the focus on “values” in the original project outline was changed to a poststructuralist inspired focus on discourses and discursive norms. This was done from a theoretical orientation which would allow me to reach further into the empirical material and question taken for granted assumptions, rather than to just locate and list values. I also wished to de-individualize the assumptions and understandings that are drawn on in mental health care. With a focus on discourses and norms, institutional and cultural rationales

may be invoked as a mode of analysis, rather than people's personal, individual beliefs. However, from the point of view of some of the study's stakeholders, this decision was not uncontroversial - and it required me to continuously negotiate the terms of the study. At times it seemed there were some specific preconceptions and expectations of the study that had not been made explicit, which made it difficult to understand the specific demands.

My co-operation with two research centers with different traditions has similarly at times led to tensions. My formal employment status has placed me in between different epistemological and ontological fields with an expectation that I was to navigate between them. The stakeholders' varied expectations to the study - as well as the fact that the study was strategically important and potentially politically charged - have encouraged me to attempt to locate a middle ground between the disciplines of psychiatry and social science. It has at times been a difficult and challenging process, but also one which has been stimulating and educational.

When I bring these reflections into the thesis, this is not just to make explicit the processes that have led to the product in the reader's hand. It is also to situate my perspectives and the discussions in the thesis in a wider social and historical context. The tensions I have experienced in bridging the fields of critical social science and psychiatry, both in the writing process, but also in my formal affiliation to two different research centers, are in no way particular to this study. The medical sociologists David Pilgrim and Anne Rogers (2005) have noted that prior to the 1970's there was a prominent collaboration between the social sciences and psychiatry, and sociologists were often active members of academic departments of psychiatry. However - partly because of psychiatry's increasing reliance on bio-medical theories, and partly because of theoretical developments towards social constructionism in the social sciences - after the 1970's the two disciplines drifted apart. Pilgrim and Rogers note that not only did the two disciplines become more distant, but mutual suspicion and contempt developed between the two. Psychiatrists blamed sociologists for the rise of the anti-psychiatric movement², and sociologists indicted psychiatry for a lack of critical reflection on the ideological nature of psychiatric theory and practice. Since then, the relationship between psychiatry and parts of the social sciences has been polarized and strained.

² The anti-psychiatric movement was actually primarily headed by dissident psychiatrists, but since they were partly inspired by sociological theories, sociology was attributed much of the blame from mainstream psychiatry (Pilgrim & Rogers, 2005)

For me, this has meant, that throughout the study I have attempted to locate a research tradition that presents a critical psychological view, which strives to bridge psychiatric and social scientific approaches. This has been difficult, and there is hardly an extensive tradition for this in Denmark. However, I have found traces of it in recent developments towards a critical and theoretically informed psychiatry and clinical psychology (e.g. Cromby, Harper, & Reavey, 2013; Double, 2006; Rapley, Moncrieff, & Dillon, 2011). There is also an increasing amount of articles in psychological, nursing and clinical journals which do invite critical and discursive perspectives (e.g. Avdi & Georgaca, 2007; Buus, 2005; Hamilton & Manias, 2006; Harper, 1995); albeit this is rarely the case in larger mainstream psychiatric journals. It is this burgeoning tradition of critical psychological and psychiatric research, inspired by discourse approaches, that the thesis inscribes itself into.

The structure of the thesis

I have structured the thesis into seven chapters. **Chapter one** introduces the thesis, its research questions and its background. It discusses the context of the contemporary mental health services in Denmark and on a global scale, with a focus on the controversies and contradictions surrounding the delivery of mental health care. Here I also explicate the terminology that is used throughout the thesis and I discuss the processes and the tensions that have led to the development of the thesis.

In chapter two I review earlier studies on the experiences of psychiatric patients, professionals' practices and studies on service user involvement, as well as specific important ethnographic studies on psychiatry. I pay particular attention to the studies' strengths and limitations and discuss the contributions of this study to the field.

Chapter three introduces my empirical field, psychiatry, in a present and historical perspective. I look at the different traditions that have contributed to producing psychiatric knowledge, and how the position of the psychiatric patient has changed historically and contextually. I also describe the functions of the contemporary mental health services in Denmark and discuss how this thesis understands the institution.

Chapter four discusses the theoretical and methodological assumptions that the thesis rests on. I discuss the thesis' epistemological and ontological perspectives, particularly the idea of situated knowledges. I also discuss more specifically the theories and concepts that I apply in the analysis, namely Foucauldian perspectives on language, discourses and knowledge, as well as discursively informed psychological concepts of positioning and subjectivity.

In chapter five I describe the settings of the fieldwork – one secured inpatient ward as well as an outpatient clinic and my access to these. I also discuss the concrete methods of participant observation and interviews with patients and professionals. Finally, the analytical procedure and my ethical considerations of the study are discussed.

Chapter six contains the thesis' analysis, which is divided into three articles, each of which approaches the topic of discourses, patient identities and user involvement from a different angle. *The first article* approaches the topic by exploring the processes of researcher positioning during the fieldwork. I examine the researcher positioning processes I became a part of and explore how these may be understood in terms of the discursive norms in the field. *The second article* centers the patients and approaches the topic by analyzing the discourses of mental illness that operated in the field, as well as their implications for patients. *The third article* centers the actions of the professionals and the possibilities and constraints for user involvement in their practices.

Chapter seven concludes the study and discusses its implications for mental health care and research. It recapitulates the conclusions of the articles and discusses their implications for the wish to implement user involvement and for mental health care. The chapter also contains reflections on my research process and the strengths and weaknesses of the study.

Terminology

Before proceeding to discuss the relevant literature on patient experiences, professionals' practices and service user involvement, it is important to explicate the terminology that will be used throughout this thesis. While it is always relevant to provide clear definitions of terms in academic work, the terms used in mental health research may be particularly politicized, with different terms carrying with them varying theoretical and political connotations

(McGrath, 2012). This is perhaps due to the contested nature of mental health and illness in general (Rapley, Moncrieff & Dillon, 2011, McGrath, 2012). In the section beneath, I will discuss the implications of the different available terms and I will make an argument for the chosen terminology.

Mental distress

There are a number of ways to define the experiences that have placed people in mental health care in the first place. Some of these are “mental illness”, “mental disability”, “mental disorder”, and “mental distress”. Each of the terms carries with it different political and social implications. “Mental disorder” or “mental disability” are used in juridical terms such as state and municipal services as an umbrella term for users of psychiatric services and neuro-cognitive rehabilitation (McGrath, 2012). It may apply to people both understood as mentally ill and those with brain damages. “Mental illness” is used in diagnostic contexts, such as those based on the diagnostic manuals DSM-5 or ICD-10. “Illness”, “disorder” and “disability”, are medicalized terms, and hence imply a bio-medical understanding of mental health problems, which has been widely contested (Bentall, 2003; Boyle, 1990; Cromby et al., 2013; McGrath, 2012; Parker et al., 1995; Pilgrim, 2005; Rapley et al., 2011). Furthermore, many psychiatric patients do not think of themselves as ill and although many have very distressing problems, they may not attribute these to an “illness” (Kinderman, Setzu, Lobban, & Salmon, 2006). Many patients therefore dismiss such illness labels or feel resentment towards them.

At the same time some social constructionist accounts have been criticized for not taking into account the very real pain and suffering experienced by the people who seek psychiatric help (Blackman, 2007; Fee, 2000). For the purpose of the thesis, it seems to me that it is necessary to find a term that does acknowledge the suffering and misery often experienced by psychiatric patients, but at the same time one that does not limit their experiences to a diagnostic illness-framework. Following other researchers within a critical psychiatry tradition, I therefore use the term *mental* or *emotional distress* in the thesis, with the intent of trying to find a de-medicalized way of discussing experiences of distress (McGrath, 2012; Speed, 2011). The terms “emotional distress” or “mental distress”, is a general term which recognizes the suffering often experienced by psychiatric patients, without adhering to a medical or diagnostic understanding. In the same way as a diagnosis tends to locate the problem in an individual disease process, the term mental distress is intended

to locate the problem in meaningful life events and in social discourses and narratives (McGrath, 2012).

A difficulty with the use of the term “mental distress”, however, is that not all human experiences that are placed under the terms of symptoms of mental illness can be correctly described as distressful (McGrath, 2012). Studies have for example found that the majority of people who hear voices or have unusual beliefs (delusions) are not distressed by these experiences – and often do not come into contact with the mental health services (Eaton, 1991; Tien, 1991; Watkins, 1998). Moreover, not all psychiatric patients in this study spoke of their experiences as distressful - and some even used words such as “exciting”, “fun” or “epiphanies”, for experiences which in their medical records were listed as hallucinations or other positive symptoms. The lack of suitable alternatives to describe the experiences of patients may reflect the cultural domination of the language of illness in defining unusual or distressful experiences. As one of the patient’s in this study said about hearing voices:

“...I have learnt more from [seeing it in my own way], than to just understand it in the sober way: that it is an illness and that is the way it is. But I don’t know what damn else to call it, that’s the main issue. I don’t really have any words”

These limitations aside, the term mental distress aims to be an alternative to a medical term of the patients’ experiences. My intention with using the term mental distress and with approaching psychiatry and the experiences of patients from this perspective is not to demonize mental health services or to undermine the fact that a number of psychiatric patients do seem to find a diagnostic illness-definition helpful (e.g. Hayne, 2003; Larsen, 2002). Rather, I wish to distance myself analytically from the prevailing understandings in the field and to point out that calling the patients’ experiences an “illness” is a metaphor - namely one way out of many possible for framing their lived experiences.

Patient as an identity category

In the thesis I make use of the traditional term “patient” to refer to users of psychiatric services, even though the term is becoming increasingly outdated in research. In recent decades, a range of alternative terms to the classical term “patient” have developed. The terms “consumer” and “client” became popular terms in the 1980’s, but were criticized by activists and researchers. It

was argued that the term's managerialist tone insufficiently captured the users' experiences of powerlessness and dependency on the system – and failed to acknowledge the significant number of people who were using the services against their will (McGrath, 2012; Sadler, 2005). The term “service user” has nowadays for the most part substituted the term “consumer” within qualitative mental health research. This is also the case in some official Danish mental health documents, where the term “user” (*bruger*) is used interchangeably with the term “patient” (e.g. Psykiatrien Region Sjælland, 2010a). However, it seems to me, at least in Danish³, that the term carries with it similar connotations of voluntary choice as the term “consumer”. In this sense, it similarly does not seem to take into account the dependency and power differences between professionals and patients. In some other countries, like the UK, the term “survivor” is an alternative term used by service-user activists and some critical researchers (Speed, 2006). The term “survivor” may refer to both surviving mental health difficulties, as well as surviving the psychiatric system - implying a degree of criticism and a contemporary anti-psychiatric discourse (Crossley & Crossley, 2001; Speed, 2006). The term is, however, still uncommon in a Danish context.

My employment of the term “patients” is not intended to inscribe the thesis in a medical tradition. In the thesis the term is regarded as a discursive category that a person occupies when she enters the mental health services, receives a diagnosis and participates in the treatment. The term “patient” is the most widespread way of talking about service users in Denmark, both by patients themselves and by professionals – and hence it is the most frequent discursive category in the field. The term “patient” in the thesis thus becomes an analytical term: it is regarded as a subject position made meaningful through practice (Foucault, 1983). From this perspective, a patient is not something that a person “is”, but rather it refers to a way of constructing a person, similarly as identity categories such as “woman” or “immigrant”. It is a social, relational category that undergoes changes and is continuously negotiated in a specific context (Holen, 2011). The term “patient” thus refers to the discursive construction of the person, as they are seen within the mental health system. When a person is rendered into a patient format she is attributed certain characteristics, written up in a file and made into a “case history” (Barrett, 1996: 13). In this sense, psychiatric institutions may be regard-

³ As one of the participants in this study pointed out, in Danish the term for user, *bruger*, is linguistically and semantically approximated to *forbruger*, consumer.

ed as sites in which patient identities are created and managed. When I discuss the people in this study who receive psychiatric treatment, I will therefore use the term “patient”. When I discuss the results of other studies, however, I will apply the terminology used by the study in question.

Although the term is approached as an analytical category, a difficulty with using the term “patient” may be that I risk reproducing the terminology – and hence the medicalized assumptions – that are present in the field. In this way, an objection may be that by using the term it may become difficult to distance myself from the prevailing understandings in the field. However, all terms at hand – patient, consumer, client and user – are terms used in the field, and so carry with them specific psychiatric/consumerist connotations. The only term which is fully independent of psychiatric terminology is the term “survivor”, but it implies that the person has taken a critical political stance towards psychiatry, which I cannot expect that all patients in the study identify with. This paradox of terminology is similar to studies that may wish to study the discursive constitution of identity categories such as “woman”, “man”, “black”, “white” or “immigrant”, but by studying these categories they cannot avoid reproducing the very same terminology. Rather than proposing a solution to this paradox, this objection will serve as an inspiration for continuous critical reflections on my own assumptions throughout the thesis.

Chapter 2: Research on psychiatric patients, professionals and user involvement

This chapter discusses relevant studies on patients' experiences, professionals' practices and service user involvement. The area of the study lies in an intersection between different research traditions: psychiatry, sociology, anthropology and psychology. It has therefore been relevant to locate literature from databases which focus on these areas respectably. I have searched the databases MEDLINE, PubMed, PsycINFO, CINAHL, JSTOR and Sociological Abstracts for literature. At different stages in the research process I have conducted searches in these databases with the keywords: mental health / psychiatry AND discourse / narrative / communication / experience; and mental health / psychiatry AND user involvement / empowerment / participation – and I have selected the articles that I could identify as relevant for this study.

The review is selective rather than comprehensive or systematic, in that I have selected the most relevant studies and studies that come close to the perspective I am applying here. The purpose of the review is thus not to account for the totality of the existing research on the area, but rather to give the reader a broad introduction to some of the ways that patients' experiences, mental health professionals' practices, user involvement and psychiatric practice in general have been researched. In each article of the analysis in the thesis I additionally make a smaller, more specific review of studies which address the particular topic of the article.

To make the review more precise I have excluded the great amount of literature on health communication in non-mental health settings, e.g. physician-patient communication in general hospitals. Because the mental health services have undergone many structural changes (e.g. increasing de-

institutionalization) and discursive shifts (e.g. the recent discourse of consumerism and managerialism) in the last decades, I will concentrate on studies from the 1990's onwards and mostly from the 2000's. I have located 33 relevant articles as well as some review studies, which will form the backbone of the discussion. To get a more local perspective I have additionally included some recent Danish monographs and some quality development studies on patient satisfaction conducted in Denmark. Finally, to acknowledge the broader research methodology that I draw on, psychiatric ethnography, in the last section of the review, I will also outline selected ethnographic "classics" conducted in mental health institutions from the 50's onwards – some of which have been a great inspiration for this study.

I have divided the review into four main sections. The first, *Research on patients' perspectives and experiences*, discusses studies which often stem from psychological research and concern "patient" or "client" perspectives on psychotherapy, psychiatric practices and relationships with professionals. The second section, *Research on mental health professionals' perspectives and practices*, discusses studies from the professional research literature, commonly found in nursing journals. The third section, *Quality studies and research on user involvement*, discusses a motley collection of research on involving patients in psychiatric treatment. I discuss the recent practice of conducting consumer satisfaction surveys in Denmark and I review some academic studies on user involvement. The final section, *Classical ethnographies of psychiatry*, deals with major ethnographic monographs, which have shaped and informed contemporary research.

Research on patients' perspectives and experiences

The first group of studies we will examine are studies that focus on patients and their experiences of psychiatric treatment. These studies have traditionally been placed quite low in the hierarchy of psychiatric evidence. Currently, what is considered the "golden standard" of psychiatric knowledge is the research endeavor of evidence-based medicine, particularly randomized controlled trials. Clinical research in the field of mental health has tended either to exclude the views of patients or to portray them as the passive objects of study (Rogers & Pilgrim, 2010). There is, however, a rising interest in qualitative studies which do explore patient experiences.

Relationship aspects of patient experiences: phenomenological studies

One widespread way of researching patient experience relies on broad phenomenological⁴ or largely descriptive approaches, based on interviews with patients during or after their mental health treatment. This tradition is most prevalent in psychotherapeutic research, with a growing amount of studies on clients' experiences of psychotherapy. Together with colleagues, I have previously conducted systematic reviews on studies on client perspectives on psychotherapy (Ringer, Sjögren, & Toldam, 2010; Ringer, et al., 2013.). We reviewed 41 studies on individual and group therapy and found that altogether four main aspects in the psychotherapeutic process are valued by clients: a) the relationship with the therapist or with other clients in group therapy - incorporating an engaged, accepting and non-judgmental stance; b) the process of opening up and sharing difficulties and painful events; c) the clients' responsibility and involvement by contributing actively in the therapy process; d) the possibility to gain new insights and skills, for example by exploring life history with the therapist or co-clients. Overall then, these studies seem to demonstrate that clients value the non-technical and relationship aspects of therapeutic interventions, rather than specific therapeutic techniques.⁵

Although these studies may be useful for the practice of psychotherapy, they are restricted to one possible component of psychiatric treatment. Indeed, a large number of patients in mental health services do not even receive psychotherapy (Bauer et al., 2012). Considerably less attention in research has been paid to how psychiatric patients experience mainstream psychiatric treatments (Denhov & Topor, 2012). However the studies that have been conducted tend to reflect the findings of psychotherapeutic studies, suggesting that psychiatric patients are not preoccupied with the technical proficiency of professionals. Instead, they seem to be much more concerned with the human and relationship features of their encounters with mental health pro-

⁴ Here by phenomenological I mean approaches which largely inductively or atheoretically try to capture the essence of patients' experiences. This may be done by a range of descriptive qualitative methodologies, such as thematic analysis, grounded theory, interpretative phenomenological analysis and so on.

⁵ This point is also supported by clinical meta-studies on common factors of therapeutic change (e.g. Hubble, Duncan, & Miller, 1999). These meta-studies on effects of psychotherapy consistently show that specific technical factors of a given therapy method are much less significant for therapeutic change than so called "nonspecific factors", most notably the relationship between client and therapist.

professionals. Informality, trust, being listened to, being taken seriously, being treated with respect and kindness and a non-stigmatizing attitude are all mentioned by patients as valuable in psychiatric treatment (Denhov & Topor, 2012; Gilbert, Rose, & Slade, 2008; Rogers & Pilgrim, 1993; Thibeault, Trudeau, D'Entremont, & Brown, 2010; Walsh & Boyle, 2009). Additionally, a study which focused on users' experiences of sedation, seclusion and restraint (Mayers, Keet, Winkler, & Flisher, 2010) found that users perceived these to result from the lack of the aforementioned qualities.

These studies on patient experiences are important in that they strive to give "voice" to an otherwise silenced group in research, and stress the importance of relationships in the provision of mental health care. However, there may be a tendency to reify the personal experiences of users; the users are constructed as feeling and experiencing individuals who are able to *reflect* on the interventions conducted by the professionals. In this way the patients' own ability to *act* and navigate reflexively within the mental health services rarely receives attention. A notable exception is a recent study conducted by Topor & DiGirolamo (2010), based on focus groups interviews with 15 users diagnosed with schizophrenia. Topor and DiGirolamo found that their informants made active choices and developed rational strategies in order to manage their contact with the mental health services. The users explained how they adapted their stories of distress depending on how they perceived individual mental health professionals or other people they talked to. In this way they did not relate to e.g. psychiatrists as to a unified category of people, but rather as specific persons whom they were constantly assessing - trying to understand what was expected in the interactions.

Topor & DiGirolamo's findings are interesting for this study, in that I similarly am interested in how patients (and professionals) act and navigate in relation to the mental health services. However, a more general remark which may be raised in relation to theirs and to phenomenological studies in general, is their limited attention to social context. Concentrating on the subjective experiences and reflections of patients, they rarely situate the patients' experiences in a broader cultural and institutional framework. In other words, the studies indeed place the subject, the patient, in the center of attention – but often forget to place her or him in a wider social context (Rogers & Pilgrim, 2010).

Ambivalence, contextualized strategies and the cultural repertoire

We now turn to another tradition on researching patients' experiences, which resists the tendency to decontextualize them. These studies are more informed by theory and often explore how patients react to and deal with powerful cultural and institutional imperatives (e.g. Johansson, 2011; Larsen, 2004; McGrath, 2012; Speed, 2006; Tucker, 2009, 2010). In Denmark, John Aggergaard Larsen (Larsen, 2002; Larsen, 2004) conducted a person-centered existential, cultural phenomenological ethnography on 15 patients who were enrolled in OPUS⁶ teams. He found that institutional discourses, based on biomedical and cognitive-behavioral models, were both reflected and challenged in the accounts of service users - who were all engaged in innovative meaning-making activities. The users either dogmatically embraced the authority of the explanatory model provided to them by professionals, or they acted as *bricoleurs* of various systems of explanation, including spiritual and existential systems. In this way, different explanations taken from the cultural repertoire were appropriated, rejected and adjusted in a continuous process of negotiation.

Larsen found that his participants' personal understandings of their psychotic experiences were vital to the process of recovery, as they afforded meaning to the confusing experiences of psychosis. Other studies have found that the process of meaning-making and identity construction can be vastly ambivalent for patients, when their problems become categorized as a psychiatric diagnosis. For example, Ian Tucker (2009) interviewed people who had been diagnosed with schizophrenia in the UK to explore how they constructed their identities in light of the diagnosis. He found that a key feature of receiving the diagnosis was to see one's identity as under threat from the many negative cultural stereotypes that persist regarding schizophrenia. The service users sometimes initially saw the diagnosis as positive in terms of providing a relief and explanation. However, after the initial relief there came a subject position with many undesirable cultural connotations. In this way, the diagnostic criteria continued to present challenges and threats to the maintenance of a positive identity. Thus, the service users continually had to make use of a range of discursive strategies to shield themselves from being placed in a negative identity.

⁶ OPUS teams are special Assertive Community Outreach teams in Denmark which are aimed at treating patients with first episode psychosis.

While a psychiatric diagnosis and the position of a “psychiatric patient” may be full of ambivalences, some studies have pointed to the legitimacy that such a position may also grant in specific contexts (Hayne, 2003; Johansson, 2011, 2010). In a study conducted in Sweden on the meaning and identity of self-harm, which combined data from 14 interviews with statements from internet message boards, Anna Johansson (2010) found that the action of self-harm became a way for patients to perform psychopathology in an “authentic way”. For the patients Johansson interviewed, cutting was a way to display recognizable signs of disorder, a way for psychiatric patients to become “authentic” and visualize their need for care in order to access the mental health services. Being an “authentic” self-harmer demanded that the informants positioned their self-harm in a psychiatric discourse and juxtaposed it to youth culture and “wannabes”. The informants pointed to the importance of being able to demonstrate recognizable signs of disorder, to visualize a need for help.

Johansson’s study is interesting for this study for a number of reasons. Similarly to Topor & DiGirolami, Johansson observes that patients are required to “manage” their relationship to the mental health system and develop strategies to navigate within it, but in contrast to them she relates this to institutional expectations. She points to a psychiatric and cultural imperative of “authenticity” and “visibility”. She thus indicates the existence of certain norms as to how psychiatric patients should act; a point which corresponds to the research interest of this study. However, Johansson focuses narrowly on self-harm and relates her conclusions to the fact that self-harm is not a psychiatric diagnosis per se. In my study, which does not focus on a particular form of distress, it will be interesting to see if a similar process of persuasion about “authenticity” and visibility can be traced.

In conclusion, the studies indicate that psychiatric patients generally seem more concerned with the human and relationship factors in treatment than the technical or medical proficiency of professionals. This justifies this study’s focus on interactions and relationship aspects between patients and professionals. However, many phenomenological studies on patient experiences focus narrowly on patients’ reflexive statements and overlook patients’ agency and their situatedness in an institutional context. The other tradition of theoretically informed studies opens up an exploration of how patients manage institutional and cultural assumptions. This perspective allows for the questioning of dominant discourses in the mental health services from the per-

spective of the patients themselves (Rogers & Pilgrim, 2010). These studies indicate a strong ambivalence experienced by patients in the encounter with the mental health services. They note that patients engage in active meaning-making processes and develop strategies in order to preserve a positive identity in light of institutional and cultural imperatives. These points will be explored further in this study.

Most studies on patient perspectives rely on interviews with patients as the sole method of inquiry. As such, they limit their scope to the reflexive statements of individuals made outside the context of everyday life (Larsen, 2004). Consequently, while the studies provide important insights into the experiences of psychiatric patients, little insight is provided into the everyday processes that shape how these experiences come about. Here, my study may contribute with a situated perspective that is close to practice. Throughout the analysis I will explore the themes of identity-negotiation, “authenticity” and patienthood in terms of situated interactions between patients and professionals.

Research on mental health professionals’ perspectives and practices

Most qualitative studies on mental health professionals that I have been able to identify are from nursing journals, and they focus on nurse-patient interactions. I will discuss these interchangeably with studies that focus on other professional groups.

Workload, paperwork and the discrepancy between ideal and practice

Much of the research on mental health professionals’ practices seem to be concerned with the discrepancies between ideals and practice. This is particularly visible in studies on nursing, and may be because the normative ideal of the nursing discipline prescribes humanistic values, warmth and empathy (Hamilton & Manias, 2006). Many researchers therefore seem to ask: how is it that psychiatric practice does not fulfill the ideals we all wish for? How is it that patients are not treated as well as we would wish?

A common explanation for the discrepancy between ideal and practice is cited as overwork and paperwork. In a meta-review on 13 observational studies on inpatient treatment facilities, Sharac et al. (2010), for instance, found that at best 50 % of staff time was spent in contact with patients, and very little time on delivering therapeutic experiences. This was partly attributed to the professionals having to engage in administrative tasks. A prominent theme in many qualitative studies, workload and time pressure are often seen as interfering with caring for and engaging with patients (Cleary, Edwards, & Meehan, 1999; Michelle Cleary, 2004; Donnison, Thompson, & Turpin, 2009; Hummelvoll & Severinsson, 2001). For instance, in an ethnographic study conducted in Norway, Hummelvoll & Severinsson (2001) found that work-related stress resulted in a discrepancy between ideology and practice. Although the nurses wished to apply humanistic and hermeneutic approaches which emphasized seeing “the whole patient”, time restraints and workload made them more inclined to apply psychiatric-medical models. Similarly, Cleary (2004) conducted an ethnographic study in an acute psychiatric unit in Australia in the context of mental health reforms. She found that the nurses experienced a stressful workload, with competing priorities and demands. Particularly, the nurses said that they had very little time to engage in “real nursing work” such as caring and being empathetic, because much of their time was spent on “non-nursing duties” such as washing up patient cups or buying cigarettes for them. As a consequence, the nurses were described as “stretched to the limit” and emotionally drained. Despite the circumstances, Cleary praises the nurses for “providing expert nursing practice” (p. 56) and for not resorting to practices that were “deliberately neglectful or abusive” (p. 56).

Although the points about stress and workload in these studies are important, there are a number of arguably problematic aspects in this research tradition. The studies tend to uncritically approach psychiatric work as a solely beneficent practice which in essence only revolves around positive relationships and person-centeredness, disregarding that the relationship inevitably involves power. In this context, time restraints are seen as restricting an otherwise “free” space of warmth and empathy. Both Hummelvoll & Severinsson and Cleary frame the work of nurses in the highly individualized and idealized terms of “caring”, “giving empathy”, and being “person centered”, whereas workload or biomedicine are framed as the villain. The researchers tend to adopt the language of their informants and their own account becomes entirely fused with the nurses. As such, rather than analyzing the assumptions in

the field, the studies just tend to uncritically reproduce them. What is an unexplored resource for analysis in these studies - the assumptions that are taken for granted and how these are put to use, absorbed, contested and condoned - becomes the key focus of my study.

Among expert discourses - biomedicine and managerialism

A contrasting tradition of researching professionals' practices does analyze professional assumptions and has a theoretically informed approach. Some of these studies have indicated that biomedical discourses, expert power and managerialism marginalize patient perspectives and work to uphold status quo in professionals' practices (Hamilton, Manias, Maude, Marjoribanks, & Cook, 2004; Harper, 1994, 1999; Middleton & Uys, 2009; Stevens & Harper, 2007). For example, in a number of interview studies with multi-disciplinary professionals, David Harper (1994, 1995; 1999) has demonstrated that professionals use a range of discursive strategies which work to secure their professional status as experts and portray service users as passive objects of brain abnormality. He argues that this understanding is inherent in the way mental distress is conceptualized generally in psychiatric practice, and thus is perpetually produced and reproduced by professionals.

Similarly, Bridget Hamilton et al. (2004) interviewed a nurse, a social worker and a psychiatrist regarding patient assessment in an inpatient setting. They found that the professionals were alert to the patients' feelings, but tended to reframe these in the medical language of psychiatric symptoms and in a management discourse. The professionals constantly reframed the patients' feelings and desires into diagnostic categories, which essentially worked to remove the patients' immediate concerns out of sight. In this way the perspective of patients were marginalized and blocked out. In Denmark, Nelli Sørensen (2006) studied nurses and nursing practices in a psychiatric hospital through a Foucauldian power analytic perspective. She found that the nurses offered patients a new understanding of themselves as subjects responsible for controlling and steering their illness, treatment and health. The practices offered the patients a new identity as medical or psychological subjects who become responsible for their own inclusion in society. The patients could re-enter society with this new identity, constructed as free, but bound by a psycho-medical power regime.

An increasing amount of studies document a tendency of the presence of a discourse of managerialism and consumerism in the language practices of mental health professionals (Buus, 2005; Hamilton et al., 2004; Hamilton & Manias, 2006; Plastow, 2010; Ware, Lachicotte, Kirschner, Cortes, & Good, 2000). In a review of studies on nurses' oral and written language in acute in-patient settings, Hamilton & Manias (2006) documented the increasing emergence of a managerialist discourse in nurses' language, which was created to suit the demand of an increasingly commodified model of mental health services. The discourses constructed patients and their progress as objects with inherent risk attached, which should be monitored and controlled as goods in a consumer society. In Denmark, Niels Buus (2005) conducted a study on communication among nurses at two mental health hospitals. Buus found that the nurses' language was a mixture of everyday language and idiosyncratic technical words with special local connotations. This language was difficult to understand for an outsider and could work as a way to maintain hierarchal positions among the nurses. Furthermore, the language was constrained by an "institutional order of discourse" which contained a managerial discourse and a medical-psychiatric discourse. The medical-psychiatric discourse re-enacted the hierarchical difference between professional groups. The managerial discourse created visibility and control of the nurses, and forced them into the practice of documenting and writing their practices down.

Summing up, the studies indicate that workload and time pressure are increasing for mental health professionals in light of the contemporary emphasis on efficiency and production. This may contribute to a situation in which the professionals have limited resources to reflect on their practice. The work of mental health professionals seems to involve contradiction between the pressure to medicalize and standardize patients and humanistic ideals about "seeing the whole person". This warrants a closer inspection of how professionals manage their day-to-day work in light of possible tensions, limited resources and an increasing commodification of mental health work. In article 3 I will explore the implications of standardization, ideas about professionalism and patient identities for the professionals when they attempt to involve patients' perspectives. In this way I will relate the professionals' practices to their implications for user involvement.

Quality studies and research on user involvement

Service user involvement has become a major political objective, and there are now surveys and questionnaires in Denmark which measure the satisfaction of psychiatric patients with services and thus the extent to which political aims have been fulfilled. User satisfaction surveys and questionnaires are relatively new in mental health, and have lagged behind other health care groups. This is likely associated with the traditional assumption in healthcare administration and research that the accounts of psychiatric patients lack credibility (Rogers & Pilgrim, 2010). However, in the last few years, studies on patient satisfaction with mental health care have been carried out in Denmark - and we start this section by discussing this type of studies.

User satisfactions surveys and studies on patient attitudes to involvement

A study on consumer feedback in outpatient treatment (district psychiatry) in Denmark in 2010 showed that 83 % of psychiatric patients declared that they had a general positive impression of their treatment, while 17 % declared that they had a less positive or negative view (Center for Kvalitetsudvikling, 2011). At psychiatric wards in Denmark the number of patients who said they had a positive impression of the hospitalization was 71 % and those with a less positive or negative impression were 29 % (Center for Kvalitetsudvikling, 2010). The same study showed that 79 % of patients declared themselves satisfied with the level of influence they had during the hospitalization and 21 % unsatisfied. In 2012 the first LUP⁷ study of psychiatric patients and their relatives was conducted, and it showed that between 90-95 % of psychiatric patients said their overall impression of the specific ward or clinic they were in was positive.

⁷ LUP (Landsdækkende undersøgelser af patientoplevelser) is a national survey on hospitalized and non-hospitalized patients regarding their satisfaction with the health services. It is initiated by Danske Regioner, the Ministry of Interior Affairs and the Ministry of Health. It is a questionnaire with questions regarding patient and carer's experiences of satisfaction, involvement, information and organization in the services. It has been conducted every year in the general health services since 2000 and in 2012 it was carried out in the mental health services for the first time.

Consumer satisfaction studies have been criticized for a number of reasons. Pilgrim (2005:83) has noted that the functions of satisfaction surveys are not clearly defined and so they can be cherry picked and selectively attended to by managers. For this reason, consumer feedback questionnaires may function more as a de facto legitimization of political goals, rather than actually working as a background for improving services (Holen, 2011). It has also been noted that their format with restrictive, forced choice categories cannot account for the underlying reasons for the responses. In this regard, high degrees of patient satisfaction may actually just as well reflect the patients' low expectations of services, rather than whether they are actually being involved (Holen, 2011). Social psychologists have long shown that notions of belief and attitude are complex and highly variable from situation to situation (Harper, 1995; Potter & Wetherell, 1987). Ratings of satisfactions and attitude can therefore hardly account for the variations of experiences during psychiatric treatment.

Some qualitative studies on user involvement have also been conducted. Region Zealand has conducted a qualitative report based on focus group interviews with three professional groups and one group of patients. The focus of the report was on the specific project "User-Led Psychiatry" and the interviews were especially concerned with how the professionals had experienced the project - and what they perceived as barriers and possibilities. The report found that both patients and professionals generally value the idea of service user involvement, but that professionals felt that there were limits to the extent of which the patients could decide in their treatment, "when they were very ill" (Psykiatrien Region Sjælland, 2012). A number of qualitative academic studies have additionally looked at patients' perceptions of service user involvement. In general, the studies report that psychiatric patients value service user involvement and wish to be more involved in the planning and delivery of services (Bowl, 1996; Connor & Wilson, 2006; Petersen, Hounsgaard, Borg, & Nielsen, 2012; D. Rose, 2003). These studies additionally suggest that patients experience the level of user involvement in mental health services as limited and insufficient.

The discrepancy between the consumer satisfaction studies, which indicate that patients are satisfied with the level of involvement and services, and academic qualitative studies, which tend to show that many patients experience these as insufficient, is interesting. The inconsistency points to the great variation there may be for patients in terms of their needs and experiences of user

involvement. This indicates a need for more in depth and complex studies of the processes that occur in psychiatric settings and their implications for user involvement – which justifies this study’s focus on complexities and contradictions.

Professionals’ attitudes as the main obstacle for involvement?

Other studies have looked at professionals’ roles in user involvement. In Denmark, Petersen et al. (2012) conducted an ethnographic study on user involvement in psychiatric rehabilitation. They found that user involvement was experienced by users as a struggle for self-determination and recognition. Similarly as the other studies on patients’ perceptions of involvement, the authors report that the users valued being able to have influence and to have their goals respected; however they sometimes experienced that this was not recognized by the professionals, who were the “real authorities”. In Petersen’s et al.’s study, there is a tendency to explain obstacles to user involvement in terms of the attitudes of professionals. When service user involvement is found insufficient in the studied setting, the authors attribute this to “negative views among professionals regarding [the users’] capability to make choices and be involved in care planning” (p. 65), without exploring in any depth the possible sources of these views. In this regard, the authors seem to suggest that a higher level of service user involvement could be implemented if the professionals were just willing to change their negative attitudes.

This tendency to attribute obstacles to user involvement to professionals’ lack of willingness to invite patients to participate seems to be echoed in interview studies that directly examine professionals’ views on involvement (e.g. Anthony & Crawford, 2000; Rutter et al., 2004; Summers, 2003). For example, Summers (2003) interviewed 14 psychiatrists in the United Kingdom on their views on service user involvement and found that the informants could be divided into three categories: optimists, rationalists and skeptics. The “optimists” talked about users and professionals as having different but equally relevant perspectives which should be afforded the same status. For the “rationalist” group, endorsement of user involvement was limited to specific fields, with user involvement seen as potentially going “too far”. The “skeptics” viewed user involvement as unnecessary and said that users had little to contribute to the development of services.

What these studies seem to share appears to be an implicit reliance on an individualized definition of user involvement as depending solely, or mostly, on individuals' reflexivity and motivation. Such a position appears to be somewhat simplistic and negates a consideration of the social context of mental health work – e.g. the tensions between contradictory discourses guiding psychiatric work found by some of the studies in the previous section. If this is the case, then user involvement is about much more than individuals' reflexivity – and should rather be studied in terms of subtle processes that occur between professionals and patients in the context of institutional rationales.

I have not been able to locate studies which look at such processes in terms of day-to-day work in the mental health services. However, in an observational study of a forum dedicated to user involvement, in which users were brought into dialog with officials, Hodge (2005) found that there were still subtle processes which reproduced and reinforced the power relations of the institution. It may be expected that officials who agree to participate in such a forum are largely positive to the idea of user involvement, and still, as Hodge shows, subtle processes of authority and undermining of patients' accounts were reproduced. The users' expressions of personal experience were only considered relevant in the forum when they could be incorporated instrumentally into dominant discourses; professional psychiatric assumptions functioned as normative boundaries, which deemed some experiences less legitimate. In this way, Hodge's study seems to suggest that constraints to user involvement cannot only be understood in terms of professionals' attitudes. This underlines the importance of studies that can address the daily practices of user involvement from a situated, contextual perspective.

Classical ethnographies of psychiatry

In the previous sections, I have mentioned some newer ethnographic studies; however the tradition of doing anthropological research in psychiatric institutions is much older. Perhaps because of its hermetic and closed off environment, asylums have appealed to ethnographic scholars since the 1930's, with the major classical studies being carried out in the 1950's and 1960's.

Reforms and total institutions in the 1960's

One of the first major ethnographies was Caudill's study (1958), during which he "went undercover" as a patient for two months. Caudill had a reformist agenda and identified several problems with the psychiatric hospital at the time, which he related to the hospital being a small static society, with limited ties to the world outside. The most influential work from the era remains that of Goffman's (1961), whose essays on the social life of patients in "total institutions" were effectively a critique of state control. The total institution is according to Goffman an institution in which the state seeks to control all aspects of the inmates' life and eliminate external influences. A prominent characteristic of the total institution is the gap between professionals and patients, who live in two separate social worlds, maintaining antagonism towards each other. Patients are subject to demoralizing practices which curb and limit the inmates' sense of self, including role dispossession, and the loss of identity. Visits from others are highly restricted and contact to the outside world is kept at a minimum.

Goffman wrote *Asylums* in an era when outpatient treatment was very unusual and most patients were hospitalized for a prolonged amount of time. Contemporary ethnographers (Quirk, Lelliott, & Seale, 2006; Schepelern Johansen, 2005) have pointed to the differences between modern psychiatric wards and the institution described by Goffman. In an ethnography of three acute psychiatric wards in London, Quirk et al. (2006) for instance, have suggested a redefinition of Goffman's focus on the impermeable aspects of the total institution to the notion of the "permeable institution" of modern day psychiatric wards. Quirk et al. note that in contrast to Goffman's total institutions, today patients stay in touch with the outside world during their stay; and ward membership is temporary and changes rapidly (patients often have very short stays and staff turnover is high).

Early processes of commodification and efficiency

This state of flux and change in psychiatric wards has partly been related to the development towards efficiency and commodification that are becoming commonplace in psychiatric care. One ethnographic study of a ward in the USA from the 1990's underlines the burgeoning processes of commodification. In her ethnography entitled *"Emptying Beds"*, Lorna Rhodes (1995) studied the culture and practice of an acute psychiatric unit. She found that the overarching concern of the multidisciplinary team involved the discharge of

patients and how to manage the shortest possible stays for them. Rhodes illustrates how the professionals used an array of variable and innovative strategies to consider “options for disposition” (p. 40) in the most efficient and timesaving ways possible. For instance, the patients’ diagnoses were often given pragmatically rather than precisely, based on what would provide the best argument for referral to other facilities. In Rhodes ethnography, there is a tangible mechanistic and instrumental theme, reminiscent of the production rate in a factory (Hamilton & Manias, 2006). Rhodes points out how difficult it was for professionals to maintain an ethical practice in such circumstances, and I have used her insightful analyses as an inspiration particularly for the third article of the thesis.

Rhodes focuses on the practices of the professionals and the pressure on them to “produce empty beds” to be available for new patients (p. 14). Hence, she is less concerned with a broader analysis of psychiatric knowledge and its effects. Two other major psychiatric ethnographies, conducted in a hospital and in community treatment respectively, have focused on how psychiatric concepts of mental illness are put to use and produce effects for patients. These are Robert Barrett’s (1996) critical study of an Australian psychiatric hospital for patients diagnosed with schizophrenia, and Sue Estroff’s (1985) study of psychiatric clients in outpatient American Assertive Community Treatment.

Dialectics of deviance and the social production of psychiatric knowledge

In his seminal ethnography “*The Psychiatric Team and the Social Definition of Schizophrenia*”, Robert Barrett (1996) drew on the social phenomenology of Alfred Schultz and Foucault’s analyses of power and knowledge. In the team he studied there was a constant tension between practices that on the one hand constituted the patient as an object of internal or external forces without a will of her own - and on the other, as an intentional and acting subject with volition. Barrett argues that in moving between these two conceptualizations of the illness and of the patient, the staff were able to effect transformations in the people they treated. Thus, the central objective of the treatment was to constitute the patient first as an objectified “clinical case” and then to put her together as a transformed moral agent. Clinical decisions among the team were based on unquestioned common sense and taken for granted terminology, which decided which of the patients’ experiences were

deemed legitimate and which were ruled out. These constructed schizophrenia as an anomalous cultural category, external to the basic categories of the social world and thus “unknowable” for normal people (299). As we will see, Barrett’s analyses on the production of psychiatric knowledge have been an inspiration for this study, and I will refer many of his findings throughout the thesis.

Barrett focuses on the practices of professionals and does not at any length explore the patients’ own strategies of relating to the psychiatric categories and definitions. The patients are depicted more as people on whom the professionals act in various ways. Another mental health ethnography, that of Sue Estroff’s, centers on the experiences of patients in relation to categories of deviance and mental illness. In her ethnography on clients of a community psychiatric treatment facility, entitled *“Making it Crazy”*, Estroff (1985) found that clients, staff and the community participated in the construction and perpetuation of a paradoxical and contradictory world. The clients’ principal distress was not due to “primary symptoms” such as hearing voices. Instead what troubled them the most were the fears, avoidance of others and their repugnance towards themselves that they developed as a result of being different from “normals” (p. 235). Estroff found that the clients’ exercise of “crazy” customarily granted them rewards that ultimately amplified their difference from the world of “normals”. For the clients, discharge and getting better often meant a loss of support and friends. Thus, Estroff argues, some of the clients may have chosen to “make it crazy” and actively pursued “being different” (p. 230). This was perpetuated by the negative evaluation of them that came with receiving a diagnosis that required a medical treatment. Estroff’s findings are interesting for this study in that they indicate that how mental distress is conceptualized has major implications for the positions that patients can take up and thus likely for user involvement. This warrants a closer exploration of psychiatric knowledge, definitions of illness and user involvement.

Barrett and Estroff approach the topic of constructions of mental illness from two different angles: focusing on the professionals and the patients respectively. This may be related to their researcher positions during fieldwork. While Barrett, an anthropologist and psychiatrist himself, worked professionally at the hospital he studied, Estroff approached the clients and largely had contact with them. Barrett (1996:xviii) notes that his position as a psychiatrist made it impossible to cross the “social chasm” and be accepted as a research-

er by patients, however, neither Barrett nor Estroff discuss at any depth the consequences of their position as researcher - and yet they appear to have been substantial. The topic of researcher positioning generally seems to be an unexplored resource for analysis in mental health ethnographies. This calls for a closer attention to the effects and processes of researcher positioning in psychiatric fieldwork, which will be pursued in this thesis in article 1.

Concluding remarks

Having discussed relevant studies on discourses, patient experiences, professionals' practices and user involvement it is possible to outline some possible contributions of this study. As we have seen, many of the studies rest on unquestioned assumptions about the nature of the patients' problems and the beneficent function of the psychiatric system - assumptions uncritically borrowed from psychiatric models. Thus, many studies do not inquire into psychiatric categories, how these are practiced and put to use, and the effects they have for patients. In this study, the exploration of taken for granted assumptions in psychiatry is one of the leading threads of the analysis. In this sense, my focus is similar to that of Barrett's. However, in contrast to his study, I will relate the question of illness discourses to user involvement, and I do not limit my attention to one diagnosis. Additionally, the focus in this thesis is broader than on the professionals' practices.

This leads us to a second possible contribution of this thesis: generally the studies seem mostly to address psychiatric practices from the angle of either patients or professionals, and thus center the experiences of one category of subjects. This allows many studies an in-depth exploration of one group of participants, but the position of the researcher and the experiences of the group that is not being centered are rarely given much attention. With my choice to approach the field from three different angles - that of researcher positioning, the positions of patients and the positions of professionals respectively - I will strive to give all three categories a position as reflexive and agentic.

Chapter 3: The madman, the asylum and psychiatry: present and past

This purpose of this chapter is to provide a brief overview of the history of psychiatry and the present context of the mental health services. I will look at psychiatry as a societal institution, with particular focus on the patients' situation and the way psychiatric patienthood has been understood in the past and present. I do not wish to discuss these issues in great detail; the chapter merely represents a very broad and basic outline, since the history of psychiatry is not the topic of the thesis. However because I am working from a situated perspective, I find it important to briefly outline the systems of thought and history of ideas that have dominated the development of the psychiatry we know today. I will particularly refer to the genealogical work of Foucault on the history of madness, and modern sociological accounts on subjectivity, psychology and biomedicine.

The chapter serves two functions: firstly, it presents an introduction to the field that I am studying and secondly, it functions as an outline to my theoretical understanding of institutions and the institution of psychiatry. The chapter will attempt to demonstrate how the concept of mental illness and psychiatry are not stable, ahistorical or constant entities, but are changeable and varying. I will outline some of the main debates that have taken place, and still do, in psychiatric research and practice. I do not seek to resolve the debates. Rather the intention is to provide a background for some of the tensions which still characterize the mental health field today.

Psychiatry as an institution

Institutions may be defined as complexes organized around a distinctive function, such as health care or education, which function as nodes of knots in ruling relations (Smith, 2002:43). They are shaped by and construct forms of consciousness – knowledge, information, facts, legal rules etc. – that override individuals' perspectives. From this perspective, inherent in the mental health services, as in any institution whose task is to help, treat or provide care for people with problems, there are specific self-stories and institutional rationales that patients are anticipated to assume (Gubrium & Holstein, 2001). In other words, the mental health services comprise an institution which operates with specific institutional epistemologies (ibid.). In the encounter with the mental health professional, the patient's problems become categorized, diagnosed and conceptualized according to these institutional epistemologies. When a person enters the mental health services, she may not experience herself as distinctively ill, or even troubled or distressed (e.g. Kinderman et al., 2006). An important function for the mental health services then becomes to work with the patients to define their problems in terms of an illness that requires psychiatric interventions.

In this light, psychiatry cannot be neutral - it cannot solely offer help based on the wishes and needs of the patients (Gubrium & Holstein, 2001). The institutional epistemologies in psychiatry are based on professional, cultural and historic notions of what it means to be a person, and what constitutes personality and mental illness (Barker & Stevenson, 2000). This implies that to understand the institution, the study cannot only examine the micro-interactions between individual patients and professionals. It must also explore the broader discourses and positions that become available to patients within the institution of modern psychiatry. These are grounded in the historical and social context that the project of psychiatry emerged from, which we will now further explore.

The birth of Psychiatry

Michel Foucault, the French philosopher, wrote about the ideas and assumptions that have underpinned western civilization's understandings of madness. Foucault traced the economic background of psychiatry to the massive unemployment created by crises in the early capitalist societies in seventeenth century Europe. During this time, the unemployed, the vagabonds, the disa-

bled and the mad were massively confined in big segregated institutions – an era Foucault calls “the great confinement”⁸ (Foucault, 2005). During this time, madness was not differentiated from other marginalized characters, and the main purpose of confinement was a general concern with order and respectability within the city.

Within the world of confinement, madness started to be conceptualized and individualized as lack of reason. Earlier in European history, the conceptualizations of madness had been fragmented, but the madman was often portrayed as an animalistic figure: both beast-like and innocent at the same time – and often as someone with a specific wisdom, reason and knowledge (Foucault, 2001, p. 77). However during the great confinement, madness, along with other forms of deviance, came to be considered a self-imposed moral detour. In the institutions of the great confinement, the inmates were therefore treated with physical punishment and violent coercion.

Towards the beginning of the nineteenth century, psychiatric discourses of insanity emerged as part of a reform movement, headed by reformists such as Philippe Pinel in France and William Tuke in the United Kingdom. Among the psychiatric reformists, the madman was no longer considered beast-like or passionate, but was seen as suffering from a disease which required treatment. Thus, the reformists entered the confined institutions and separated the mad from the other inmates. The mad were placed in special institutions, previous leper colonies, which were devoted to the treatment of the insane. The project was finalized with the introduction of a medical person into the new asylums. With this, Foucault argues, a new relation between insanity and medical thought was born. The doctor became the ultimate representative of objectivity and rationality, offering salvation if the patients objectified and subordinated themselves to him. In this way, care over the mad became the domain of medical science – and a new technical-rational and objectifying understanding of madness emerged. At the same time, the old moral understanding of madness had not been erased. Thus, Foucault argues, these origins of psychiatry have resulted in two discourses of madness, which still inform contemporary psychiatry: a moral discourse of salvation through

⁸ This version of the history of psychiatry has been disputed by other historians of psychiatry (e.g. Porter, 2002; Shorter, 1997: 5). They point out that the era of the ‘great confinement’ seems to have been largely limited to France and not as widespread in other European countries. E.g. by 1826 in England only about five thousand people were incarcerated, for the most part in the private sector (Shorter, 1997)

individual responsibility and a technical discourse of treatment through scientific medicine (Barrett, 1996:16; Foucault, 1984:164).

The reform movements of Pinel and Tuke are often depicted as a story of liberation and humane enlightenment, but for Foucault they represent the emergence of a new kind of power and surveillance over the mad. By a range of techniques, the overt physical punishments which had been carried out by persecutors in the institutions of the great confinement, became replaced with surveillance and internalized guilt, which were installed in the mad (Foucault, 1991a: 151-152). With the emergence of psychiatric practice then, the power over the mad did not decrease, but just took on a different form. The old institutions had worked through a very visible power of representation, manifestation and corporeal punishment; with psychiatry the power became more efficient, “multiple, automatic and anonymous” (Foucault, 1991b:192).

It is important to note that for Foucault, the developments in psychiatry do not only reflect discourses that were specific for the institution. Together with the birth of other institutions, such as the prison and the hospital, the birth of the asylum in the enlightenment era contributed to developing a particular modern relationship between subject and object, reason and unreason, rationality and irrationality. Through these developments, unreason became constituted as “the other” - as knowable only from the side of reason (Miller, 1986). Thus, the birth of the asylums represents the victory of rationality and the ultimate separation of it from irrationality. Foucault (2006) argues that during the time of confinement, imprisonment and punishment, there had been a dialogue of struggle between reason and unreason. However, with the conceptualization of madness as mental illness, this dialogue was broken. The truth about madness becomes something that could only be understood within the realm of reason, and so the mad person was deprived of the ability to say anything meaningful on her condition (Miller, 1986). The language of psychiatry thus became, and “a monologue by reason *about* madness” (Foucault, 2006: xxviii, original emphasis).

In his work on psychiatry, Foucault paints a broad picture of how psychiatric discourses became the main regime of defining the mad. He is less concerned with the challenges, struggles and conflicts which have surrounded psychiatry since its emergence. In the next section I briefly sketch out some of these controversies and struggles.

Competing notions of mental illness: Psychiatry as a discursive battlefield

Psychiatry has been called the “the most contested field in medicine” (Hornstein, 2009:6, cited in Harper, 2011:53). Disputes about whether mental illnesses are brain diseases or alternatively not illnesses in any sense of the word, have been and are still constant in psychiatry. Although most of us associate criticisms of psychiatry with the anti-psychiatric movements of the 1960’s and 1970’s, the medical specialty psychiatry has actually encountered skepticism and criticism from the very beginning of its emergence - quite unlike other medical specialties (Miller, 1986; Møllerhøj, 2007). For instance, Møllerhøj (2007) has documented how Danish psychiatrists already in the nineteenth century complained in journals, textbooks and newspapers about the public and state authorities interfering and questioning psychiatric practice. These early criticisms stemmed from the public and relatives of patients, who questioned the ethical aspects of psychiatric methods and the discipline’s scientific status. Thus already in psychiatry’s early childhood, it was faced with the “problem of the public opinion” (Møllerhøj, 2007), which has haunted it ever since.

However, also internally in psychiatric practice and research, there have been struggles concerning the function of psychiatry and the nature of mental illness from the beginning. Among the internal struggles in psychiatry, the debate has traditionally consisted of two camps: on the one hand those who mainly believed mental illness stems from a biological deficit associated with hereditary factors (traditionally the “somatics”), and on the other those who believed that it emerges from social and psychological stressors (traditionally the “psychics”). The contrast between these paradigms is important in the context of the present day mental health services, as both arguments have consequences for how psychiatric patients and their distress are constructed, and the types of interventions that become possible.

Within the biological paradigm, the most valid intervention is seen as medication. Since the difficulties of patients are seen as stemming from a chemical imbalance or other problems in the brain, the cure becomes to attempt to alter brain chemistry. The socially oriented position on the other hand, advocates psycho-social interventions, psychotherapy, social guidance and sometimes political change. These two paradigms may be seen as intimately connected to the “moral” and “technical” discourse lying at the foundation of psychiatry, which I discussed in the previous section. As Barrett (1996:254)

has noted, the two paradigms epitomize different conceptions of who the psychiatric patient is. The biological-technical approach asserts that the person with schizophrenia is categorically *different* from other people due to an inherent brain disorder, whose actions cannot be interpreted as meaningful besides in terms of their genetic makeup or brain functioning (Barrett, 1996: 254). Psychosocial-moral approaches state that the person with schizophrenia is basically *the same* as other people and their behavior can be understood as reactions to their situation (Barrett, 1996). Different eras have seen the dominance of different models of explanation. However, there is general consensus that in the last many years with an expanding pharmaceutical industry, psychiatric research and practice have greatly found their inspiration in the medical or biological model (Moncrieff & Crawford, 2001).

The current theoretical model which formally guides psychiatric practice and research, the bio-psycho-social model (Engel, 1980) developed in the 1970's, is regarded by many as a type of compromise between the two paradigms, which ended a centuries long discussion on the aetiology of mental illness (Møhl & Simonsen, 2010). According to the bio-psycho-social hypothesis, mental illness arises from a combination of biological, social and psychological factors – in that stressful life events are thought to work as “triggers” for pre-existing biological vulnerabilities. However, the extent to which the bio-psycho-social approach actually does acknowledge a causal role for psychosocial elements has been contested. The psychologist Mary Boyle (2011) has argued, that while the model seemingly does acknowledge a role for environmental factors, the significance of these are actually negated. Boyle suggests that the implication of the model is that negative experiences are not in themselves harmful, but become so because of a biological vulnerability in the person; thus, there is an assumption that “normal people” would be able to cope. In this way biological factors are held to be much more fundamental and prior. Similarly, Barrett (1996: 247) has noted that with the emergence of the bio-psycho-social model, psychiatric science could dominate antipsychiatry and other psycho-social approaches by incorporating them into a bio-psycho-social model which reaffirmed the primacy of biology – and so, he argues, it has secured biological reasoning as the dominant position in psychiatry. Barrett (1996: 245) observes that prior to the bio-psycho-social model, low social class, migration and social isolation had been attributed a causal role in schizophrenia, but with the introduction of the model, these factors went through a shift to become secondary aspects, or just factors influencing the prognosis of the illness.

These critical voices notwithstanding, bio-psycho-social psychiatry has expanded and gained in influence throughout the 20th century. The contemporary significance of both psychological and biological models of mental distress may be understood in relation to social developments and modern definitions of subjectivity in western cultures. In order to make sense of these developments, I briefly discuss the work of modern sociologists with an emphasis on the work of Nikolas Rose.

Proliferation of the psy disciplines and therapeutic cultures

The medical sociologist Nikolas Rose (1996) notes that since the inter-war year, there has been a proliferation of sites for the practice of psychiatry. He argues that an increasing amount of social phenomena have come to be identified within the domain of what he calls the psy disciplines: psychology, psychiatry, psychotherapy, psychoanalysis. The psy disciplines are “intellectual technologies” that serve to make “visible and intelligible certain features of persons, their conducts, and their relations with one another” (Rose, 1996:10). With these developments there has been an increasing psychiatrization of new problems, a proliferation of the psychiatric population, as well as a multiplicity of techniques for normalization (Rose, 1986). Rose (1986) suggests that the contemporary mental health system aims not only at eliminating mental illness, but to manage all aspects of life in order to produce and maintain mentally healthy citizens.

Rose argues that psychological vocabularies have come to play a crucial role in the rationales and techniques of social government, such as in the army, medical establishments, among politicians and in schools (Rose, 1990). And so, people in general have started to understand themselves as psychological, and have begun to live out psychological models in their own talk and experiences. The psy disciplines therefore function as a type of social regulation, but not one aimed at repressing people and controlling deviants. Instead, people are being regulated internally, by using the psychological models and by thinking about themselves as people who could always have better psychological capacities. In this way, people increasingly learn to govern their own subjectivities and self-monitor their mental health status.

Rose’s account of the psy disciplines bears resemblance to the concept of “therapeutic culture” developed by Frank Furedi (2004). Furedi has argued

that western culture increasingly makes sense of social problems, marginalization, inequality, racism and sexism through the individualized tone of therapeutic discourse. This has fostered a climate in which the internal world of the individual is the primary site in which social problems are sought to be resolved. The language of psychotherapy constructs a common sense understanding which regards people's behavior and feelings as the outcome of internal causation: personal inadequacies, guilt or internal conflict. According to Furedi, this framing of the problems of everyday life makes people feel vulnerable, powerless and ill. In this way it imposes a new conformity through the management of people's emotions.

Both Rose and Furedi are mainly interested in the regulatory and surveillance aspects of the psy-disciplines and therapeutic culture. However, along with researchers such as McLeod & Wright (2009), it can be argued that this perspective may not pay sufficient attention to the situated ways in which therapeutic and psy rationales are negotiated contextually. McLeod & Wright argue that although psy-based practices may be a way to regulate subjectivity, in some contexts they can potentially open up transformative and productive possibilities for marginalized people. Thus, an account which only focuses on the negative and social regulatory aspects of therapeutic and psy models may ignore the sense of capacity that such models may also afford in some contexts. When I raise the reflection that psy and therapeutic cultures in the daily lives of marginalized groups may also have positive effects, the intention is not to dismiss the regulatory and powerful aspects of such discourses. Neither is it to disregard the importance of structural inequalities or to argue for a romanticized view of "personal change". Rather, the point is only to highlight that the effects of the psy disciplines are perhaps more contradictory and multi-faceted than their portrayal in some sociological accounts (McLeod & Wright, 2009). This underscores the importance of studying these processes from a situated, local perspective in relation to the everyday experiences of groups of people.

Neurochemical selves in the 21st century

In his later work, Rose has argued that in the last few decades, with the popularization of psychopharmacology, brain imaging techniques and developments in genomics, people in western societies have increasingly come to understand their minds and selves in terms of their bodies and brains (Rose, 2003, 2007). Mental conditions are increasingly understood as caused by un-

derlying chemical imbalances in the brain. These conditions are increasingly thought to require interventions by drug treatment that may “re-balance the chemicals” (Rose, 2003). According to Rose (2003), Western societies are increasingly becoming “psychopharmacological” societies. In such societies, the boundaries between normalization of pathology and the enhancement of capacities in general are becoming fuzzy. Human subjectivity can potentially be routinely re-shaped by psychiatric drugs. The task of the responsible and active citizen then becomes to take control in the name of maximizing his or her potential, to engage in constant risk-management, to monitor the moods, emotion and cognition in a continuous process of self-scrutiny (Rose, 2007).

Rose argues that this development has brought with it a fundamental shift in the relations between mental health and illness, and is linked to a transformation in our conceptualization of personhood. In as much as the previous conception of personhood was grounded on the ideas of the psy disciplines, in the 21st century we increasingly think of ourselves as somatic and neurochemical individuals.

For psychiatry, according to Rose, this has meant that from the 1990s on, there has been an important shift in psychiatric thought and practice. Although there is little firm evidence which links mental illnesses to neurotransmitter functioning in the brains of unmediated patients (Moncrieff, 2008), a new way of psychiatric thinking has taken shape. In this new paradigm, the explanations of mental illness must “pass through” the brain and its neurochemistry to be legitimate (Rose, 2003). This does not mean that biography, trauma, social and environmental factors are ruled out, but rather that they are considered to have effects through their impact on the brain, again affording biological explanations primacy. As Rose notes, some 25 years ago, such claims would have seemed bold. This shift has reshaped how both professionals and lay people interpret, speak about and understand themselves and the world. Individuals who have never come near psychiatric hospital are beginning to speak about their moods as chemical imbalances, and act upon themselves in light of these understandings.

After this brief overview of sociological accounts of the history of ideas of psychiatry, we now turn our attention to the historical developments in Danish psychiatry and its present situation. This is provided in order to situate this study in a more local and concrete context.

The mental health services in Denmark

A brief history of Danish psychiatry

Danish psychiatry has to a large extent developed historically parallel to its sister-institutions in other countries. The first psychiatric hospital in Denmark opened in 1816, as Sct. Hans hospital in Roskilde, and it was rebuilt and expanded in 1860. In 1852, a first modern-type of psychiatric hospital was inaugurated in Risskov and by the end of the nineteenth century there were five more psychiatric hospitals in Denmark (Vaczy Kragh, 2010). From about 1840, Danish physicians who worked with madness saw it as a physical and biological illness. Curiously, according to Møllerhøj (2005), the most important argument for the focus on biology and heredity in Denmark was religious and metaphysic: since the idea of a “sick soul” went against the protestant Christian teachings of the immortality of the divine soul, it had to be the body/brain, not the soul/mind that was somehow dysfunctional (Møllerhøj, 2008).

The focus on mental illness as a physical disease became stronger towards the end of the century. Psychiatric practice and research in Denmark, headed by the physician Knud Pontoppidan (1853-1916) concentrated on identifying concrete, localizable damages to tissues or organs (Møllerhøj, 2008). This parallels the attempts in other countries to provide legitimacy and an air of science to the new project of psychiatry. At the same time, just as in other western countries, in 19th century Denmark, the most widespread form of psychiatric treatment became moral treatment, adopted from Tuke and Pinel - a treatment aimed at having a mental or spiritual influence on the patient (Shorter, 1997). Moral treatment was understood as a system of upbringing of the patients, which aimed at teaching the patient a sense of order and moderation and thus to work on their inner mental life. Thus, although Danish psychiatry had a strong commitment to biological and hereditary understandings, in practice it relied on moral understandings which were not addressed or fully acknowledged by the psychiatric establishment (Møllerhøj, 2008). This inconsistency points again to the tension that, as we saw, lies at the very heart of psychiatry: the tension between a moral discourse of subjective salvation and a technical discourse of medical treatment.

Although moral treatment was common in psychiatric hospitals, the biological, hereditary paradigm remained the most dominant explanation for mental

distress until the 1940's when psychoanalysis gained greater influence in Denmark (Hansen, 2008). In the 30's and 40's Danish medical journals such as *Ugeskrift for Læger* and *Hospitalstidende* had vivid discussions about the legitimacy of psychoanalysis, psychology and pedagogics in psychiatry. In 1948 the *National Association for Mental Hygiene* (Landsforeningen for Mentalhygiejne) was established, with the aim of spreading knowledge about mental disease as connected to the inner world of people - and as related to social, environmental and personal factors (Hansen, 2008). In this way, psychosocial understandings of mental distress gained greater footing in the world of Danish psychiatry after the Second World War. This paved the way for developments such as de-institutionalization and anti-psychiatry.

De-institutionalization and anti-psychiatry

As in most of the Western world, there was a large shift in the Danish institutional practices and policy towards mental illness in the second half of the 20th century: known as *de-institutionalization*. In Denmark this new way to structure mental health care, informed by community psychiatric approaches and involving a closing of the great asylums in favor of outpatient treatment, was called "district psychiatry". The first time the term "district psychiatry" was used in an official Danish document was in 1965 (Lindhardt, 2001). Up until 1976 the mental health services functioned as large state hospitals with the number of inmates ranging from 500 to 2,000 (ibid.). In 1976 the total number of beds in psychiatric hospitals in Denmark was 12,700 (Lindhardt, 2001). In the latest report on access to psychiatric services among adults, issued in August 2012, the total number of beds in Denmark was 2,745 (Rigsrevisionen, 2012). These developments have been accommodated by a physical and administrative placement of the psychiatric institutions in the somatic hospital system.

Prior to, and parallel to de-institutionalization and the establishment of outpatient "district psychiatry", new critical perspectives on psychiatric practice had appeared in Denmark, as in many other countries. The criticism came from dissident psychiatrists, psychologists and service-user movements. In 1960 the American psychoanalyst Thomas Szasz (1974) published *The Myth of Mental Illness* in which he argued that the idea that mental distress was an illness was a myth based on inconsistencies and misunderstandings detrimental to patients and society at large. The same year the British psychiatrist Rold D. Laing (1969) published the book *The Divided Self* and joined the psychiatrist David Cooper to head the anti-psychiatric movement. Previously the sociolo-

gist Erving Goffman (1961) had published the work *Asylums*. In Denmark, much of the anti-psychiatric criticism was put forward by a combination of Marxist and Freudian theory, which emphasized the oppressive nature of institutions (Hansen, 2008).

Today, while psychiatric wards still exist, their function is less one of lengthy “confinement” than of spaces for short-term stays with a goal to discharge quickly into the community. In 2011 the average stay at a psychiatric ward (excluding forensic patients) in Denmark only lasted 18.04 days (Deloitte, 2012). At the same time, the number of outpatients has risen considerably. The result is that mental health professionals in wards now appear to rather manage the movements of a constantly changing groups of patients (Buus, 2005). These developments have also been spurred by another reformist agenda, intimately entwined with the agenda of de-institutionalization, but also associated with other reforms in the welfare state of late capitalist societies: namely that of neo-liberal ideologies.

Neo-liberal critique and transformations in the welfare state

The process of the closing of asylums and de-institutionalization has often been portrayed as a story of liberation which ended an era of abuse by dehumanizing “total institutions” and began the move to a more modern and humane treatment (McGrath, 2012). Nonetheless, it has been noted that de-institutionalization, although assisted by activist movements, matched the aims of a wave of neo-liberal politics in the 1980’s (Hansen, 2008; McGrath, 2012). In this way, de-institutionalization seemed to have had both economic and ideological roots.⁹

In the 1980’s and 1990’s, in Denmark, there arose a project of modernization of the welfare state. It was built on a neo-liberal critique, which portrayed the welfare state as a pacifying colossus that made individuals dependent and weak (Hansen, 2008). Large scale state-implemented projects were expensive and were becoming increasingly less popular. Meanwhile the political climate

⁹ Some historians of psychiatry (e.g. Shorter, 1997) have attributed de-institutionalization to the introduction of antipsychotic drugs - specifically the invention of chlorpromazine - claiming that the effects of the psychotropic drug made it possible for patients to live in normal community settings. However this version of events has been widely refuted, since it has been shown that an increased pattern of de-institutionalization began prior to the distribution of chlorpromazine (cf. Gronfein, 1985; Rogers & Pilgrim, 2010)

increasingly stressed individual's responsibility and freedom of choice. The concrete strategies of the project of modernization were to decentralize the public sector, to expand the private sector and to create options of freedom of choice for citizens, who were increasingly construed as consumers (Hansen, 2008).

In Denmark, these reforms in the public sector played a key role in the processes of de-institutionalization of the mental health services and the rise of district psychiatry. With the neo-liberal reforms, citizens were expected to become active and responsible agents who took responsibility for themselves and were involved in solving social problems (Hansen, 2008). The closing down of the asylums matched these ideologies: a large collective system was replaced with one which partly delegated responsibility for living, treatment, distress and recovery to the individual patient instead of the institution (McGrath, 2012). In this context, ideas from Marxist movements went hand in hand with the neo-liberal processes, as they both emphasized empowerment, agency and responsibility.

So far we have looked at the historical processes, which have contributed to the formation of the psychiatric system that we know of today. We now turn to outline the present context: the contemporary organization and administrative functions of the mental health services in Denmark.

The functions and organization of the contemporary mental health services

The mental health services in Denmark are placed under the general health services. The health services have the purpose of taking care of the population's health, as quoted in the Danish Health Act (Sundhedsloven, www.retsinformation.dk, *my translation*):

§ 1. The purpose of the health services is to promote the population's health and to prevent and treat disease, disorder and disability for the individual person

The health services in Denmark are divided into 5 regions, with 98 municipalities. The mental health services are responsible for three areas: adult mental health services, child and youth mental health services and forensic mental health services. In all areas two models of treatment are provided: outpatient treatment in clinics or day centers and inpatient treatment at wards or psychi-

atric hospitals. The idea is that psychiatric hospitals with inpatient treatment are for the acutely ill, while other patients receive psychiatric care via outpatient treatment. Inpatient care is considered temporary and thus the wards are not places where the patients can live. However, some patients do stay for longer periods of time, and forensic patients sometimes stay in psychiatric hospitals for years. Many psychiatric institutions and centers have a mixture of forensic patients (i.e. who have been sentenced to treatment following a crime or felony) and non-forensic patients. There is, however, also a special psychiatric hospital (called *Sikeringsafdelingen*) with specialized care for forensic patients (www.retsinformation.dk).

Means of coercion and restraint are permitted in psychiatric treatment in Denmark, and the Act on Restraint in Psychiatry (*Lov om anvendelse af tvang i psykiatrien, lovbekendtgørelse nr. 1111 af 1. november 2006*) is more permissive towards means of physical restraint than for instance in the United Kingdom. It authorizes the use of: containment, compulsory admission to psychiatric hospitals, compulsory treatment, restrains such as belt-strapping and sills for the hand and foot as well as the use of physical power (www.retsinformation.dk). According to the law, means of restraint and coercion are only to be used after other means have been exhausted and if “the patient is insane or in a state that may be given equal status to it, and if it will be irresponsible not to confine the person” (*Chapter 3, Lov om anvendelse af tvang, www.retsinformation.dk*, my translation). Approximately 6 % of all adult psychiatric patients were compulsory admitted to a psychiatric hospital in 2007 (www.bedrepsykiatri.dk).

The government has formulated the aim of the mental health services to be a user-centered and specialized “world class psychiatry” (Danske Regioner, 2009a). To reach this aim, eight visions have been put forward: to increase the knowledge and comprehension of mental illness in the population; better prevention of mental illness; to treat everyone with a need for psychiatric care; to cure a larger number of people; to make the mental health services more accessible; to decrease the excess mortality among people with mental illness; to have the necessary technology and a well-functioning physical space; and to have enough qualified workforce and to make use of it in the best possible way.

These are broad and general aims, which hardly stir much controversy. However, the practical ways to reach them are under debate. Currently, a much

larger sum of public spending is used on the physical health services than on the mental health services (Danske Regioner, 2009b). The mental health services also suffer from a lack of trained workforce, especially psychiatrists. This has been attributed to medical students opting out of psychiatry as a specialty – likely due to its low status in comparison to other medical specialties and the public stigma associated with the discipline (Danske Regioner, 2008). Some regions have attempted to fill the gaps by recruiting doctors from other European countries (Deloitte, 2012), however, there is still a lack of psychiatrists in most of the country's regions. In 2008 approximately 15 % of all positions for psychiatrists in the adult mental health services and 30 % in child and youth mental health services were left vacant (Danske Regioner, 2008).

The general directions of health politics, such as health acts and other laws governing the mental health services, are passed by the state, while the responsibility for financing and structuring the content of the treatment and care lies with the Regions. Negotiations and contracts between the state and the regions are made every year, and these structure the financial possibilities and demands about productivity. However, the content of treatment is also co-governed by the state organ *The Danish Health and Medicines Authority*, (Sundhedsstyrelsen). Sundhedsstyrelsen supervises and accepts the Regions' hospital plans and health plans and has influence on the overall organizational planning and the contents of hospitals.

The regions are obliged to implement and make use of the quality system The Danish Quality Model (Den Danske Kvalitetsmodel - DDKM). In short, the DDKM is built on centrally defined standards for accreditation of good quality, which set guidelines for how the mental health services should function. A similar model has been functioning in the physical health services since 2005, and in the last years, the model has been revised and transformed to fit the mental health services. An external accreditation team surveys the progress with regular intervals and evaluates whether a specific ward or clinic lives up to the standards. If the standards are met, the specific facility becomes accredited; if they are not, they can get an accreditation with remarks or be denied accreditation. The results of the accreditation process are made publicly available (www.ikas.dk).

Another new development to achieve the goals of cohesion and efficiency is the introduction of so-called “package procedures” (*pakkeforløb*).¹⁰ These are standards that set the exact procedure and amount of time to be spent on each individual patient as divided by diagnosis. For example, for unipolar depression the standards are: 1 hour diagnostic assessment; 1 hour physical examination; 5 hours consultation on medication; 6 hours individual psychotherapy *or* 12 hours group therapy; 1,5 hour health guidance; 1,5 hour meeting with relatives; 1 hour for coordinating the treatment with other authorities; 1 hour for closing the treatment (www.psykiatri-regionh.dk). So far (in the summer 2013) nine packages have been implemented for nine diagnostic types: anxiety and phobias, bipolar disorder, unipolar depression, periodic depression, eating disorders, personality disorders, post-traumatic stress and obsessive-compulsive disorder. The packages mean that a patient’s treatment is considered complete when the procedures and timeframe described in the packages have been followed.

Overall, the activity in the mental health services has increased significantly in the last years. From 2001 to 2011, the amount of adult psychiatric patients treated in the regional mental health services has risen by 25 %. In the same period of time the amount of child patients has increased by 165 % (Deloitte, 2012). In 2011 the total number of adults in Denmark who were psychiatric patients was 94,336. The same year the amount of beds for inpatient treatment was 2,323. This means that 4 out of 10 patients only receive outpatient treatment and have not been hospitalized over a 10 year period (Deloitte, 2012).

Concluding remarks

The chapter has indicated how psychiatry may be said to constitute a discursive battleground in which different discourses and representations of patienthood have strived, and still strive for definitional rights. The different discourses which define patienthood and subjectivity are relevant for the thesis in the sense that all these ways of understanding mental illness and psychiatry’s function provide different ways to position patients. They may also provide different discursive norms that become available to patients and pro-

¹⁰ This is similar to some models of Managed Mental Health Care, e.g. applied in the US (cf. Ware et al., 2000)

professionals, and which may shape how they can act, think and relate to the mental health services. The psy disciplines position the patient as someone with a profound inner psychological space which needs to be monitored, counseled and transformed. The neuro-chemical discourse positions patients as repositories of chemical abnormalities that need to be fixed by medications. On the one hand the modern discourses of psy and biochemistry may be associated with the traditional discourses of “somatics” and “psychics” in psychiatry – and the historical tension between the moral and technical discourse. On the other hand, they may represent a peculiar late modern development. The analysis will explore how some of these discourses take on local forms, and how simultaneously, other norms and discourses are developed in the practices of patients and professionals.

At the same time as it provided a brief history of ideas of psychiatry, the chapter has aimed at making the reader more familiar with the context of the modern mental health services: their structure, recent reforms and challenges facing patients and professionals. We should now be better equipped for understanding the context for this study. In the next chapters I move closer to the study by discussing the theoretical and methodological perspectives that I employ.

Chapter 4: Theoretical and methodological perspectives

My analyses find their theoretical inspiration in poststructural theories on discourses, practice and subjectivity. Specifically, the theoretical tools have been developed from the work of Foucault and later discursive psychologists inspired by his work. Foucauldian perspectives have primarily been used in studies on “macro-level” analyses of political social processes of change and greater cultural movements – they are less common in psychology (Alvesson & Karreman, 2000; Willig, 1999:3). However, the analytical tools are also suited for studies on meso and micro-levels in contexts that are not traditionally considered political, especially when a Foucauldian discourse perspective is combined with poststructural theories on subjectivity. Before I turn to discuss the thesis’ central theoretical concepts, however, I will briefly outline the main ontological and epistemological assumptions that the thesis rests on.

The epistemology and ontology of the thesis

Much research on mental health operates with what has been dubbed a “direct” or (more condescendingly) a “naïve realist” perspective (Harper, 2004). “Direct realism” is a usually tacit assumption, inspired by the natural sciences, that there is a direct relationship between what is observed in the study, and the nature of reality in general, which is believed to be rule-bound and static. The psychiatric diagnostic manuals DSM-5 and the ICD-10, for example, are built on a belief that psychiatric symptoms are intrinsic qualities in patients that may be rightfully delineated through careful observations or rating scales performed by the clinician or researcher (*ibid.*). An important task for the researcher who is working within a direct realist paradigm therefore becomes to attempt to eliminate her own influence to foreground reality, as it is crystallized in the data.

The “linguistic turn” that has been informed by post-modernism, poststructuralism and social constructionism has questioned the ontological and epistemological stance of realism, arguing that the social world (including the social world of research) is made up of discursive practices and is historically and socially contingent. Meaning is considered to be a social, situated phenomenon produced in a specific cultural context (Järvinen, 2005). Among discursive researchers then, there is a tendency towards relativism and skepticism towards many of the knowledge claims of realist-oriented research.

The issue of relativism has been approached in a number of ways. Some social constructionists take the stance of radical relativism. According to a radical relativist perspective, all forms of knowledge claims are constructed, and no insider perspective may be privileged, as they may all be considered language games implicated in power - not moves towards the truth (Haraway, 1988). Within psychology perhaps the most radical claims for relativism have been put forward by Edwards, Ashmore, & Potter (1995), who have argued that the debate between relativism and realism itself can be dismissed and approached as rhetoric. In their article, Edwards, Ashmore & Potter attempt to deconstruct as rhetoric arguments that physical things (such as furniture and human catastrophes such as genocide) have a material reality that is not only language.

Here, I agree with researchers like Ian Parker (1992, 2002), Carla Willig (2008) and Donna Haraway (1988) who point out that there are at least two problems inherent in such a radical relativist stance. First, a relativist perspective makes it difficult to maintain the project of social change in critical science. If no situation can be argued to be better than any other, movements for social and political change risk becoming groundless (Parker, 1992). A second risk concerns relativism on an epistemological level: the idea that no scientific account can be viewed as more valid or “objective” than others leaves little space for arguing for the validity or importance of any scientific study (Haraway, 1988).

My thinking about ontology and epistemology has been much inspired by the work of the feminist poststructural researcher Donna Haraway (1988). Haraway calls for a reinstallation of the term “objectivity” in feminist research, which has been denied by radical social constructivists. She envisions a feminist version of embodied objectivity: one which has a commitment to faithful accounts of the real world, while still maintaining that all knowledge claims

are historically and socially contingent. The solution, she suggests, is a conceptualization of feminist objectivity as *situated knowledges*. By viewing all knowledge produced by science as situated, Haraway argues that no knowledge can be “from everywhere”, but is always created from specific positions. This way, research should never be seen as whole and total, but always as partial and stemming from certain positions. For Haraway, realist and relativist notions of knowledge and reality are equally problematic, as they are both guilty of the same sin: denying the importance of location, position and embodiment. She writes:

“Relativism is the perfect mirror twin of totalization in the ideologies of objectivity; both deny the stakes in location, embodiment, and partial perspective; both make it impossible to see well.” (Haraway, 1988: 584)

In contrast, by thinking of all knowledges as situated, local and partial perspectives, Haraway argues, we may make knowledge claims that are valid in the sense of being faithful accounts of the world from a certain perspective.

Following the idea of situated knowledges, this thesis is critical to the notion of an objective, universal truth, but accepts the possibility of specific local and social forms of truth, with a focus on everyday life and stories (Kvale, 1997: 227). To work from a situated perspective means avoiding the temptation of having a neutral and objective vision “from above” (what Haraway (1988: 581) calls the “*god trick of seeing everything from nowhere*”). It also involves a constant sensitivity to the positioning of the researcher and the relationship between the researcher and the researched. Finally, working from a situated and partial perspective implies a moral, political and critical commitment to locating oneself within the positions of the “subjugated”, as this makes it more possible to acknowledge the critical and interpretive core of all knowledge (Haraway, 1988).

However, working from a situated and partial perspective is not without its difficulties. In the case of psychiatry, in which multiple and often mutually exclusive and contradictory knowledges co-exist how may the researcher situate herself? Claiming a straightforward “patient perspective” I believe may be considered illusory. The assumption that the researcher is able to completely and fairly represent the experience of members of a marginalized group is deceptive. A further difficulty presents itself when we ask: whose situated knowledge and perspective of “the subjugated” should be privileged? Is it only the perspective of patients that may be considered “subjugated”? Claiming

that only patients represent a subjugated knowledge I believe to be somewhat simplistic. As Lorna Rhodes (1995:8) has compellingly demonstrated, the local knowledge of mental health professionals may also be said to constitute a subjugated knowledge - as it is highly contextual and fragmentary, and contrasts with the formal knowledge of diagnosis, administration and law.

My understanding of the situatedness and partiality of knowledge is reflected in the structure of the analysis in which I consider three partial perspectives. The first article on researcher positioning is explicitly written from a researcher perspective and the researcher functions as the main locus of action. The second article, on illness discourses, attempts to center the experiences of psychiatric patients; the patients function as the protagonists who develop strategies to conform to and sometimes challenge the norms and discourses in mental health care. The third article aims at centering the experiences of mental health professionals and the difficulties they experience when they try to involve patients in the treatment.

The intent of pursuing three angles is not to say that I believe that it is ever possible for the researcher to actually place herself in a different person's perspective. Instead, they present an approach to knowledge, which acknowledges that all perspectives developed by the researcher are partial and interpretative. Additionally, the point of pursuing different angles is also to create a nuanced account that looks at different angles when approaching the topic of study. In this way I hope to produce results which do not reduce the complexities of psychiatric practice to a question of locating "villains" and "heroes". It is my wish to produce a thesis that is meaningful for the people it concerns, and in the best case, an inspiration for reflexivity and potential social changes.

In terms of my own situated knowledge, many reflections throughout the PhD have concerned my moral, personal and political position in relation to the institution of psychiatry. This type of reflexivity is always necessary when conducting qualitative research, but in the case of this study it became paramount. This is especially so because, as mentioned, my concrete situatedness and formal employment status has placed me "in between" different epistemological and ontological fields. The placement of the PhD project as a co-operation between on the one hand the psychiatric services of Region Zealand and the Psychiatric Research Unit (which for the most part is engaged in traditional quantitative clinical research) and on the other at the Department

of Psychology and Educational Studies (which for the most part is engaged with qualitative, critical social research) has created tensions regarding my positioning. The expectation that the study contributes to new research that is meaningful and useful for both sites has been a source of continuous reflections.

The starting point of these reflections has been that it is important to make explicit the ontological and epistemological premises that have informed the research - both to myself as a researcher and to the broader audience. There are many different normative/political stances towards the mental health services, ranging from largely enthusiastic about new developments within clinical research and psychiatry - to various radical accounts aimed at abolishing the whole enterprise of psychiatry. I have strived to find a way to approach the functions of psychiatry from a critical and theoretically-informed, yet open position: one which on the one hand acknowledges the misery and distress experienced by many patients and their need for therapeutic care – but on the other a position which does not deny the power inherent in psychiatry in defining patients and the sometimes adverse and violent effects of psychiatric treatment.

The work of Foucault - and his understanding of power, knowledge and discourses as not simply oppressive, but also as productive - has helped me think about psychiatric practice as a site of production and “identity work”, in which discourses unfold and shape subjectivities. At the same time, I have strived to develop an approach which takes serious the participants’ differentiated and diverse “perspectives” and their experiences not only as constituted by the institution of psychiatry, but also as lived experiences which can or sometimes cannot be made meaningful in the dominant discourses of psychiatry. In the following sections, I outline my main theoretical inspirations in closer detail: the work of Foucault and later psychologists inspired by his work.

Central theoretical concepts

This section is divided into two parts. I begin by outlining my perspectives on language, discourses and practice, which I relate to the institution of psychiatry. Here I also discuss how discourses are implied in the production of knowledge and power by creating specific norms which become naturalized

forms of truth. In the second part of the section, I discuss my understanding of subjectivity and experience. I will suggest that if poststructuralist approaches wish to embrace the complexity of human experience, they need to move beyond a focus on discursive practices and a formulation of “selves” as merely contextual and constantly fleeting discursive formations. The second part therefore deals with the thesis’ understanding of subjectivity and personhood, specifically related to Rom Harré’s theories of positioning and subjectivity.

Foucauldian perspectives: Language, discourses and knowledge

Language as a discursive practice

From a discursive perspective, the language used in interactions is not simply a description of reality. Rather it has a function and an effect within an interaction, namely a performative aspect - and it draws on sets of wider understandings. Thus, instead of studying language and discourse as a route to discovering some aspects of an underlying personality or a “true” underlying reality, language and stories become the object of study themselves. An example from my fieldwork will serve to illustrate this point. The following situation took place during my first day of fieldwork at the ward:

After the morning meeting I stay and chat for a while with a young woman who is staying at the ward, but whose name I haven’t yet caught. I ask about the rules at the ward and she explains them to me. I ask her if it’s difficult to understand me, since I have a Swedish accent. She says “a bit” and apologizes if she seems unfocused. It’s because she’s psychotic, she says. And because she has so many diagnoses. She lists them: borderline, ADD, anxiety and depression. I ask her what she thinks about the diagnoses. She says she thinks she lacks one: Tourette’s syndrome.

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My perspective on language means that with statements like the one above, my focus is not primarily on the participant’s “personality” or on her diagnoses per se. What becomes more interesting are the possibilities opened up and shut down for her, when she talks about herself this way (Speed, 2011: 125). For instance to call oneself “psychotic” as the participant above, opens up other possibilities of subjectivity and is different from calling oneself a “voice hearer” (ibid.). What is also of interest are the positions that the diagnoses make available - when they seem to be so present for the participant that she

lists them immediately. An additional point of inquiry would be the implications of the diagnostic identity categories for her - which leave her wanting yet another diagnosis.

From this perspective, then, language practices such as speaking or writing, do not merely describe, but are involved in the production of subjects and objects. This implies that the way we talk about something is important, because people situate their experiences and understandings within a discursive context (Willig, 2011). This way, the language used in psychiatry and the interactions between patients and professionals may have an impact on the patients' understanding of who they are and the positions they can occupy in psychiatry. However, it is not only the content of verbal utterances that carries with it discursive meaning. The tone of voice, body language and facial expressions may also be crucial for how a statement can be heard (e.g. Barrett, 1996:98ff). Similarly, a person's position in an interaction will also shape how a specific statement may be understood. For instance, even if the exact same sentence is uttered by a professional and a patient, it is likely that these will be heard and interpreted differently - due to their varied positioning within the mental health services.

When the thesis refers to language, therefore, it defines it as the discursive practices that happen on a day-to-day basis between patients and professionals, between different professionals, as well as between different patients. However language also may become naturalized, mixed with other practices, materiality and institutional rationales to create discourses. And when we speak, we are always drawing on specific discourses. As the poststructural sociologist Stuart Hall (1997: 131) has noted:

“Subjects may produce particular texts, but they are operating from within the limits of the episteme, the discursive formation, the regime of truth, of a particular period and culture”

In this way, discursive practices, such as spoken and written language always emerge from a specific place. A person's statements may thus not only be considered “private”, but a reflection of specific broader discourses that the person draws on. The discourses may also decide what counts as meaningful statements in a certain setting (Barad, 2003). In the next section I explain in more detail how I use the term “discourse” and “discursive norms” in the thesis.

Discourses and norms

In theorizing discourses, institutions and norms I draw inspiration from the work of Foucault. From this perspective, discourses make available particular ways of ordering and making sense of the world, including ourselves, and what we experience as true and real. This is a broader definition than for example that used in linguistics, where discourse refers to segments of speech or writing (Hamilton & Roper, 2006). As Parker (2002) noted, a Foucault-inspired analysis of discourse is not primarily concerned with the specific rules and rhetorical conventions of mundane talk; rather, it explores “serious speech acts”, institutionalized talk or practices. Thus, its interest in language takes it beyond the immediate context within which language is used by specific speakers (Willig, 2008).

Discourses may be regarded as wider systems of meaning that shape what can be thought, said, and done in specific situations. Thus, they may be defined as groups of signs and practices that systematically form the objects and subjects of which they speak (Foucault, 2004:54). In this way, discourses provide particular ways of ordering and making sense of the world, including ourselves.

An example of an influential discourse is the biomedical discourse, which is powerful in mental health care. The biomedical discourse comprises ways of understanding bodies, patients, doctors and hospitals, as well as ways of acting as a patient, doctor and nurse (Hamilton & Manias, 2006). As we have seen the biomedical discourse emerged towards the end of the eighteenth century, with the birth of enlightenment. For psychiatry, the biomedical discourse, which took hold of life in the asylums of that era, meant that madness for the first time became conceptualized as a mental illness, in line with other medical specialties. Madness became standardized, objectified and rendered the object of scientific study. Since the biomedical discourse of mental illness has a long history and has gradually become more taken for granted, for many people it will have become a naturalized, common-sense knowledge. Thus, few people would nowadays conceptualize the distress of psychiatric patients as something other than a mental illness - indicating the power of this discourse in defining these types of human experiences. However, the biomedical discourse is not the only discourse associated with psychiatric care. Several other discourses may be identified, e.g. a moral discourse of care, a social discourse concerning poverty, a psychological discourse (Rose, 1996), and recently, a neo-liberal consumerist discourse. Due to its novelty (as mentioned, it emerged with market forces from the early 1980's), the con-

sumerist discourse may still be less taken for granted, and therefore more visible precisely *as* a discourse to professionals and researchers than e.g. the biomedical.

Although discourses are relatively powerful, they are never all-embracing. Counter-discourses are always possible and do emerge eventually (Foucault, 1980). An example of a counter-discourse in the psychiatric context is the assemblage of diverse practices which emerged in the 1960's and 1970's under the heading of "anti-psychiatry". Additionally, psychiatric counter-discourses have lately found a revival in movements like critical psychiatry (e.g. Double, 2006) and postpsychiatry (e.g. Bracken & Thomas, 2001) and in survivor movements like the Hearing Voices Network. Counter-discourses are less powerful or legitimate, and Foucault refers to them as subjugated discourses (Foucault, 1980).

Discourses are historical and continuously emergent rather than constant. They gain their matter of fact quality since they are bound up with institutions and institutional practices (Willig, 2008:113). In this sense, there is a dialectic relationship between discourses, institutions and practice: discourses legitimate and reinforce institutional structures, but the structures also support and validate the discourses (ibid.).

Discourses draw on and produce discursive norms that create and restrict possibilities of defining who patients and professionals are. In this sense, the term "norms" is not intended to be understood as rules which oppress or force people. Rather, they are understood as naturalized understandings which inform the person about legitimate ways of being and acting. The person uses the norms to guide and regulate her actions. Through these interpretational practices, local discourses may also come to life and assert themselves in the specific practices in which they exist. In this sense, generalized truths about psychiatric practices as well as local, specific truths and norms, which have emerged in specific contexts at specific wards and clinics, may co-exist. The norms become taken-for-granted ways of acting and thinking, and with them certain practices become legitimate ways of acting from within particular discourse while others do not.

Since discourses make available certain norms and types of subjectivities (e.g. as mentally ill) they are implicated in the exercise of power. From a Foucauldian perspective, the psychiatric practice of assessment, diagnosing and treat-

ment may be seen as an exercise of power and discipline, a practice of the “medical gaze” that produces and reproduces deviance (Foucault, 1991c, 2005). However, this does not mean that Foucault necessarily equates all forms of power; not all subject positions are repressive (Heller, 1996). Power is therefore not in itself evil, power is simply the ability to modify the actions of others. This is a point in which the work of Foucault is often misunderstood and requires some further discussion.

Knowledge, power and freedom

Foucault (1983) challenges the notion of a pre-existing subject who acts, thinks and experiences on her own. Instead, the subject for Foucault refers to discursive practices of power which shape human subjectivity. He writes:

“There are two meanings of the word subject: subject to someone else by control and dependence, and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to.” (Foucault, 1983: 212).

In this sense, Foucault argues, power and knowledge create the subject. Ways of acting and the ideas used to attribute meaning to actions are perceived as emerging from power exchanges and language (Hamilton & Manias, 2006). Similarly, discourses gain their influence from relying on knowledge and power. The most powerful discourses are those that have won power-struggles and have become supported by the establishment of new institutions, education and research. The psychiatric discourse of mental illness, for instance, is in a stronger position than the anti-psychiatric, since it is a discourse which claims higher legitimacy as science. Scientific discourses are ascribed a higher degree of truthfulness – i.e. they will often count as unquestionable truths. As Parker (1992:8) has noted, discourses construct representations of the world which have a reality nearly as coercive as gravity. And like gravity “we know of the objects through their effects” (Parker, 1992: 8)

However, Foucault strongly resisted the view that power is necessarily synonymous with the exercise of domination. Instead, power for Foucault is a relation. In this sense, power in psychiatry cannot be explained as only being a “top down” process that goes down from the professionals to the patients, or even from the state or economy to the professionals. Instead, the professionals, patients, administrators and other actors and institutions are bound together in the same disciplinary space, and are all, to variable degrees, subjects of power (Rhodes, 1995:7). Moreover, power is not necessarily oppressive.

Rather, its foremost characteristic is that it is *productive*, in the sense that it produces subjects, discourses and truths. This point of Foucault's has sometimes mistakenly been interpreted as meaning that all power is productive, and that repressive power does not exist (Miller, 1986). However, this is not the point that Foucault seems to be making. In talking about power as productive, Foucault was attempting to reconceptualize power, and its relationships to lives of individuals, discursive practices and specific social categories such as the "mad" (Miller, 1986:40). In relation to such phenomena, power is seen as having a productive and constitutive function (in that it creates these categories), not simply one of repressing individual's subjectivity (ibid.). In this sense, subjectivity is perceived to be constituted in and through the operations of power relations. Power is understood as a technology present in all social relations, which occur when a person acts upon the actions of others. Foucault writes:

"When one defines the exercise of power as a mode of acting upon the actions of others, when one characterizes these actions as the government of men by other men – in the broadest sense of the term – one includes an important element: freedom. Power is exercised only over the free subject and only insofar as they are free" (Foucault, 1983:p. 221)

Freedom, in this sense, is not the absence of power - but rather they are intertwined and linked. Foucault has been criticized for not being able to account for the kind of power that is detrimental and the kind of power that may be liberating. The critics of Foucault have argued that since the subject is produced by power, it is impossible to talk about aspects of liberation. In line with Heller (1996), however, I suggest that this may be a misreading of Foucault. The criticism may only be considered valid insofar as the notion of freedom is equaled to the absence of power. For Foucault, liberation does not mean being free of power or being free of discourse. Instead liberation is possible when there are multiple discourses and counter-discourses available. From this perspective, positioning within some discourses can therefore allow for liberating subject positions.

Perspectives on subjectivity: Discourses and positioning

Discursive approaches on the study of "health", "illness", "mental illness" and psychiatric institutions have been successful in developing an understanding of the social, historical and cultural situatedness of these. However, in order to answer the research question, the thesis needs to attempt to move

beyond a critical deconstruction of the dominant discourses of mental health in order to explore how these are adopted, modified or challenged by the concerned individuals.

The critical health psychologist Carla Willig (2000) has noted that in discursive work on health and illness there has been little discussion of “exactly *how* discourse may be implicated in subjectivity and *how* experience may be mediated by discourse” (p. 553, original emphasis). The discursive constructions of psychiatric patienthood, of narratives of mental illness and recovery provide a frame of reference for the ways in which we are able to experience ourselves, our identities and our bodies over time (Frank, 1995; Willig, 2000). This thesis is concerned with both aspects: the discourses *and* their implications for subjectivity, including how the discourses are appropriated, resisted, negotiated and disputed. Thus, the theoretical task becomes to theorize embodied subjectivity while maintaining a commitment to a Foucauldian discursive approach. In other words, the focus of the thesis goes from the availability of discursive resources in the mental health services to how patients and professionals appropriate, resist and otherwise deal with them (Willig, 2000).

The medical sociologist Nick Fox (1997) has drawn on Foucault’s later work to argue that Foucault was primarily concerned with how we become “desiring subjects”, that is, how we express our bodies and desires within a subjectivity capable of reflection. Towards the end of his life, Foucault himself acknowledged a need to shift focus from institutions and social processes towards understandings of self-processes and self-formations. He writes:

“I’ve insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of the self” (Foucault, 1988, cited in Fox, 1997)

This was pursued to a greater extent in his later work, but it did not develop to a full theorization of subjectivity. Foucault’s work, therefore, leaves questions unanswered regarding the relationship between individual agency and discourse. Hence, the majority of research working with a Foucauldian perspective has paid significant attention to discourses themselves as “macro-processes”, rather than working with the relationship between discourse, practice and experience (Willig, 2000). Some versions of postmodernism have therefore been accused of “killing the subject” or of operating with an “emp-

ty, grammatical “object” [...] a fragmented, anonymous, dead self”(Crossley, 2000, p. 41). In order to answer the research questions, the study must explore how available discourses and practices constitute subjectivity: how the individual is both constituted by the discourses and yet uniquely purposive and reflexive (Willig, 2000). This implies that the theoretical perspective must accommodate a move between discourses and institutions on the one hand and everyday life, sense-making and subjectivity on the other.

As much as some Foucauldian perspectives avoid a focus on subjective experience and may have a tendency to underestimate the notion of personal agency (Benwell & Stokoe, 2006), there are other discursive traditions that do equip the person with much agency. These are often informed by linguistic and conversation analytic approaches. In contrast to Foucauldian approaches, which largely regard the subject as constituted by discourse, these approaches regard the person as an agentic “discourse user”. Before I move on to describe the perspective on subjectivity and discourse that is the main perspective in the thesis, positioning theory, I will briefly outline one of these theories. This short interlude is provided in order to explicate some of the strengths and limitations of other discursive approaches to subjectivity, and thus to make more explicit my choices and eliminations. Although there are many versions of the subject as “discourse-user”, we will look at the version of discursive psychology that has its roots in ethnomethodology and conversation analysis (Potter & Wetherell, 1987) - partly because it is one of the most influential discursive approaches within psychology, and partly because it was the theory that I originally considered employing as a main framework of the thesis, but largely moved away from.

The problems with the person as “discourse user”

Discursive psychology was developed towards the end of the 1980’s as a radical alternative to cognitive psychology. The traditional cognitive view assumes that people have a coherent core-self that can be identified within the inner world of the person. Language is seen as an externalization of underlying thoughts, attitudes and motivations. Jonathan Potter & Margaret Wetherell (1987) argued strongly against this notion of mental life and aimed to show that language is not a reflection of internal inner states, but performative of them (Benwell & Stokoe, 2006). They wished to demonstrate that what traditional psychology assumed to be psychological phenomena were actually social activities. Accordingly, language is seen as used by people as a means to

achieve certain ends. In relation to identity and selfhood, Potter & Wetherell argue that psychology must:

“...displace attention from the self-as-entity and focus it on the methods of constructing the self. That is, the question becomes not what is the true nature of the self, but how is the self talked about, how is it theorised in discourse?” (Potter & Wetherell, 1987, p. 102).

With this follows that people’s talk is variable and dependent on the social interaction. How the “self” is expressed, for instance, depends on the specific setting and the function that the expression serves (Crossley, 2000). Discursive psychology’s topic of study thus became the rhetorical strategies that people use to construct credible and believable versions of the world that serve particular social functions (Potter, 1996, p. 151).

The great value of approaches such as discursive psychology is that they are sensitive to an analysis of what goes on in the very moment when people interact. Discursive psychology has developed a range of conceptual linguistic tools to apply for the analysis of conversation and language in use, some of which will also be used in this thesis. However, with its attention to everyday interaction, it sometimes forgets to relate the discourses of everyday use to broader social, political, historical processes and issues of power (Parker, 2002)¹¹. In this study, in contrast, an understanding of the wider context in the constitutions of subjectivity, psychopathology, and selfhood are of key importance.

Furthermore, and more important for the present discussion, although discursive psychology has much focus on the person’s agentic strategies and active involvement in conversations, it still does not seem to sufficiently theorize subjectivity: who the person that is using the rhetoric strategies is - and how it happens (Alvesson & Kärreman, 2000). The person appears as a strategic, functional and rational agent. The experiencing, emotional, embodied person still appears to be absent, and the notion that humans have a fundamental or internal “sense” of themselves as selves is downplayed (Crossley, 2000). The result is sometimes a notion of selfhood in which “subjective ex-

¹¹ This argument may apply to some accounts of conversation analysis and discursive psychology, but not to others. Some accounts do mix discursive psychology with Foucauldian theory or other approaches that involve cultural and historical contexts. E.g. Wetherell (1998) has argued that the distinction between poststructuralism and conversation analysis is painted to sharply and advocates for a synthesis of the two.

perience... is made so context-dependent, so fluid and flexible, that there seems to be little beyond a personal psychology which is a moment-to-moment situated experience” (Augoustinos & Walker, 1995:127, cited in Crossley, 2000).

A brief example may clarify these points. In one of the interviews an informant told me that she had been sexually abused as a child by a male member of her extended family - and that the voices she heard belonged to her abuser.¹² How may such a statement be understood and analyzed without a notion of an experiencing subject? It would be somewhat problematic, I believe, to focus solely on the form of the statement as serving a function within an interaction; as e.g. an interactional tool used to persuade the interviewer of a specific version of reality. Instead her statements may rather be approached in relation to notions of embodied experiences and meaning-making: emerging thoughts, feelings and self-narratives as well as how these are tied to cultural discourses on gender, sexualized violence, victimization, family-relations, psychopathology and so on.

What emerges from this is that individuals are not simply “discourse users”. Discourses have effects, sometimes harmful, and the relationship of cultural categories to embodied experience needs to be analyzed with this in mind (Blackman, 2005). Thus, although discursive psychology provides important insights into language and rhetorical strategies used in interaction, the interest of this thesis lies in the intersection between discourses and practices on the one hand, and subjectivity on the other. Here, therefore I draw inspiration from positioning theory.

Positioning and selfhood

A number of poststructural researchers have used the Foucauldian concept “subject position” in order to develop an account of subjectivity. With the concept of subject position people are seen to be continually constituted by processes of positioning in discourse. The work of Rom Harré (Davies & Harré, 1990; Harré & Gillett, 1994; Harré & van Langenhove, 1999) provide a useful framework for understanding subjectivity and interactions as discursive - and is a key inspiration for theorizing subjectivity in the thesis.

¹² Although rarely acknowledged in psychiatric textbooks, this is a common among people diagnosed with schizophrenia. Sexual abuse is one of the most frequent factors found to precede voice hearing and psychotic experiences (Ensink, 1992; Whitfield, 2005).

Positioning theory (Davies & Harré, 1990; Harré & van Langenhove, 1999) was developed as an alternative to the traditional concept of “role” in social psychology. It regards humans as agents, active in their contribution to a larger discourse, and as people who are applying meaning to what is said and to who he or she is (Harré & Gillett, 1994: 113). From this perspective, in any conversation, people position themselves, position others, or are being positioned by others in a process of identity negotiations. Positioning may be either intentional and conscious or unintentional and tacit (Davies & Harré, 1990). Positioning consists of a distribution of a set of rights, duties and obligations, which have implications for what the person can do, say or think while being located in the position (Harré, 1998). For instance, in a meeting between a patient and psychiatric professional, the patient may position herself or be positioned by the professional as a victim of illness. The position of victim may imply the right of being cared for, of being met with empathy and compassion. It may also grant the person the right to deflect personal responsibility for a difficult situation. At the same time, the position of victim may imply the duty of remaining passive rather than active, as well as avoiding a too energetic stance in changing the situation. In this sense, the positions imply rights and duties and hence have social consequences and functions.

Positioning always draws on wider discourses and norms, which are inseparable from the context of the interaction. For instance, in the situation above, the position as a victim of illness may be tied to broader discourses on illness, “the sick-role” (Parsons, 1975), madness, hospital institutions and medical authority. The positions are further intimately connected to social power relations. This implies e.g. that the victim-position may much more easily be granted to the patient than to the professional in the interaction. However, regardless of a potential power asymmetry in the interaction, the conversation is a mutual engagement between two agents. A person may disagree with a positioning, challenge it or refuse it. The patient, perhaps having seen that the position of victim of mental illness involves a passivity she does not wish to embrace, may attempt to position herself as someone who is not suffering from illness. In that case a negotiation may occur, where a secondary positioning may or may not be agreed upon. Thus, people have the possibility of attempting to refuse, negotiate or modify positions, preserving personal agency. However, because the positions are tied to discourses and powerful institutions, they may be pervasive and breaking with them may lead to inertia.

Subjectivity as privatized discourse

Although many subject positions which are taken up in discourse are temporary and transient, others are more permanent (e.g. woman or man, black or white). If a person is continually positioned in a specific way, she may learn to understand and orient her actions, thoughts and feelings towards the network of meanings inherent in the position. For instance, being continuously positioned as “manipulative” by psychiatric staff (as tends to be the case for women diagnosed with borderline personality disorder, see e.g. (Nehls, 1999; Ringer et al., 2010)), is likely to affect how a person views herself and her possibilities of participation in the mental health services. What initially originates from the social reality of language thus develops into an internal subjective orientation (Willig, 2000). In this sense, psychological phenomena can be seen as privatization of public discourse. This orientation towards psychological phenomena and long-term narrative identities is what distinguishes positioning theory from the type of discursive psychology inspired by conversation analysis. Harré & Gillet (1994) suggest that through learning to use the words “I”, “me”, “mine”, the child learns to see itself as an experiencing agentic person. Thus, when we use the first person pronoun “I” we produce selfhood discursively for others - and at the same time we produce it discursively for ourselves. This creates a sense of personal identity and a feeling of having an experiencing self.

From this perspective, subjectivity is both distributed and personal - conditioned by the social and institutional contexts that an individual participates in and by her ability to make sense of and reflexively engage in these contexts. Harré (1998) suggests that internalized discursive positioning constrains and opens up possibilities for what a person is able to do and feel, even when they are alone. In this sense, a patient who has been positioned and positions herself as a victim of mental illness for a prolonged time, may learn to attribute her personal sensations, thoughts and feelings to the illness, while continuously viewing herself as unable to change them.

Positioning theory has been criticized for leaving some questions regarding experience and subjectivity unanswered. For instance, it may be difficult to account for why some people continuously position themselves in ways that are negative or deteriorating to their identities (Willig, 2011). While this critique may be justified, I find that for my focus the theory entails great strengths. The combination of positioning theory and Foucauldian analysis allows for an exploration of the intersection between discourses, institutional

landscapes and patient identities, which is the focus of the thesis. In this sense, the thesis foregrounds the institutional context and the experiences of subjects within it, rather than a theory of subjectivity.

I will use the positioning concept as a way of exploring the interactions between patients and professionals in psychiatry and as a way of understanding how the patients may adopt, refute, modify or privatize the discourses that become available to them within the institution - as well as draw on other discourses. Positioning theory holds that the person experiences a sense of continuity while at the same time developing temporary selves in conversation. This allows me to carefully speculate about how the temporary, discursive selves that arise in interaction may affect the person's subjective experience and sense of self. At the same time, the positioning concept is sensitive to issues of power, exclusion and inclusion in interactions. I therefore apply the concept of positioning not only as a way of studying the subject positions that become available to patients and professionals, but also as a way of understanding and situating myself as a researcher, which is discussed at length in the first article of the analysis (Ringer, 2013).

Chapter 5: Study design

In this chapter I describe the design of the study and the process of production of data. The chapter also contains reflections on the process of access, and of ethical considerations. The question of researcher positioning will not be discussed at length, as it is the topic of the first article of the analysis.

The settings of the fieldwork

My choice to study more than one psychiatric setting was motivated by a wish to allow for diversity and variation in the data. At the same time I did not wish to be scattered over too many places, since I wished to immerge in each setting for a longer period of time. For the purpose of variation (Polkinghorne, 2005), I therefore found two settings to be an appropriate choice.

For my research interest, I wished to study settings that allowed for the development of long-lasting relationships between patients and professionals. I therefore excluded psychiatric emergency services, where patients are either referred to another institution for long-term treatment or sent back home after a few hours. The choice landed on two settings: an outpatient clinic and an inpatient “locked” ward. My research motivation for selecting institutions that varied in their structure and organization was to strive for diversity (e.g. Denzin, 2006). I expected that everyday life, institutional cultures and the challenges facing the participants in an inpatient ward and outpatient clinic would vary significantly. Thus, if it was possible to point to similar patterns, understandings and discourses across the settings, despite their differences, this could strengthen the results. If, however, there would be significant variations in the patterns, these could contribute to an understanding of complexity and local constructions.

Access to the settings

Prior to the fieldwork, I had meetings with the two head nurses¹³ of the districts that were involved in the study, during which tensions emerged regarding where the fieldwork should take place. It was implied that one district was afraid that the project would be a comparison of how well the districts manage user involvement. This subtle tension reinforced the decision that the fieldwork should be done at two very different facilities, an outpatient clinic and a closed inpatient ward. This way, no comparison could be conducted, since the institutions functioned in very different ways. After a few meetings we settled on one specific ward and clinic which could be of interest. The head nurses contacted the charge nurses of the facilities and asked them if they wished to participate in the project. They both agreed. After having received the immediate acceptance from the charge nurses I held meetings with the rest of the staff at the ward and clinic, during which I presented the study, listened to their input and answered questions. I also provided written material about the study (Appendix 1).

One of my initial ideas was to focus on patients diagnosed with borderline personality disorder. This wish was based on my prior knowledge of the field and of how patients with this diagnosis have traditionally been perceived in clinical practice: the diagnosis has often been given to female patients who become problematized or even disliked by professionals (Horn, Johnstone, & Brooke, 2007; Ringer et al., 2010). Given my interest in problematized patients and a long-held interest in gender, this patient group seemed to be of particular interest in the study. However, in the meetings with the head nurses during which access was negotiated, it was explained that this would not be in the interest of the region, since Region Zealand wished for the study to focus broadly on all patients. I thus changed the focus to include all patients in the settings. And so the fieldwork was carried out in the spring and summer of 2011.

¹³ It is difficult to translate the Danish titles of professionals directly. Each district in Region Zealand has a head nurse who is responsible for all the psychiatric teams in the region. When I refer to these nurses who are in charge of a whole district and usually do not work directly with patients, I use the term “head nurse”. Every psychiatric team additionally has a nurse in charge who together with the chief physician, makes up the management of the team. When I refer to the nurses who are team leaders, I use the term “charge nurse”.

The outpatient clinic

The outpatient clinic was placed in a medium-sized town in Denmark and occupied two floors in a three story building. The team consisted of 13 mental health professionals who provided services to between 250-350 patients with different diagnoses. At the time of the study there were 280 patients with contact to the clinic, out of which 20 patients were forensic, i.e. received compulsory treatment after a sentence. At the time of the fieldwork the clinic had recently changed its focus – from being primarily considered a long-term treatment facility it had become a general facility with both long-term (previously called “chronic”) patients and more short-term patients.

The permanent professional group consisted of a management – the psychiatrist and the charge nurse as well as the team members: four nurses, two occupational therapists, two health care assistants¹⁴, one doctor with the function of general physician, a psychologist and a social worker. At the time of the fieldwork there were also three nursing students who passed through as well as a physician resident.

Except from the doctors and the psychologist, all team members were generalists; individual team members worked as case managers¹⁵ and had mixed caseloads including patients with a range of conditions. Apart from the function of case manager, the team also organized a range of group activities for patients, group psychoeducation¹⁶, education on healthy lifestyles, evenings for patients’ relatives and group therapy.

The team was working hard on implementing the newest standards of care developed by the Danish Quality Model (DDKM) (cf. Chapter 3). One to two of the new instructions were brought up during each morning meeting; one of the team members would project the new instruction onto the wall for the team to see and read it out loud, followed by a discussion of how it could

¹⁴ Danish health care education is divided into a short education for health care assistants (*social- og sundhedsassistent* and the former *plejer*), who train for less than two years, usually by a combination of short theoretical and lengthier practical courses, and a longer education for nurses, occupational therapists and physiotherapists which lasts approx. 3-3,5 years .

¹⁵ The term ‘case manager’ has been translated from the Danish *primær kontaktperson*. Each patient was assigned a case manager who had regular meetings with her/him and who organized the treatment.

¹⁶ Psychoeducation stands for patient education about their diagnoses, and could be either in a group or individual format.

be understood and/or implemented. Many of the professionals felt an increasing pressure to perform as a result of the new standards and ideals of efficiency - and experienced feelings of pressure and stress. The standards required every team members to register the amount of face-to-face contact with patients every day. These were then summed up and the collective output of the team was measured in accordance to the set standard for minimal patient contact. The standards did not include phone calls to patients, e-mail contact, meetings with relatives, or contact with the municipalities, which meant that these activities, often a necessary part of psychiatric work, were not accounted for. Furthermore, one meeting with a patient was registered as one service, regardless of how long the meeting lasted. The standards therefore encouraged the professionals to keep their meetings with the patients as short as possible - and to have many short meetings with a large number of patients. Some recent budget cuts had also resulted in the dismissal of one of the team's colleagues who had worked in the team for 18 years.

The treatment philosophy of the team was based on cognitive-behavioral approaches and most of the team members had received training in cognitive-behavioral techniques. Apart from meeting with a case manager, patients were offered a range of group activities, e.g. psychoeducation, group therapy, groups for relatives and groups for promoting a healthy lifestyle. The patients had widely varying difficulties and many different diagnoses. The average length of treatment was approximately 6 months; however the forensic patients and the patients who were in treatment with Leponex (a strong antipsychotic which demanded that patients had to be closely monitored and discharged only by a psychiatrist) were in contact with the clinic longer. The patients were usually referred to the clinic after hospitalization or from their general practitioners, and they usually had meetings with their case managers once a week or once every second week. The meetings either took place at the clinic or in the patient's house, although because of the pressure to keep the meetings shorter they increasingly took place in the rooms devoted to this purpose at the clinic.

The inpatient ward

The ward was also located in a medium sized town and it occupied one floor in a building surrounded by other wards. It was structured as a traditional ward; centrally by the entrance to the ward there was a staff room with large windows covering the walls, allowing the professionals to look out onto the

ward. There were 14 single bedrooms and some rooms reserved for activities such as watching television or playing table-tennis. The mental health team consisted of approximately 27 mental health professionals and a number of substitutes who worked in shifts around the clock, providing services to 14 in-patients with varied diagnoses. Among the professionals, there were 23 nurses and healthcare workers, a psychiatrist, a physician resident, an occupational therapist and a social worker. The ward also had an affiliated psychologist, but during the time of the study the psychologist was involved in other tasks, and so was rarely seen at the ward.

The patient group was a mixture of forensic patients and non-forensic patients. Among the non-forensic patients some were at the ward voluntarily and others were receiving compulsory treatment. One patient had been at the ward for half a year, as he was awaiting a sentence, but otherwise the stays were usually shorter, lasting from a few days to 3-4 months. A large amount of the patients were “repeaters” or “revolving-door patients”, i.e. patients who were well known to the professionals and who had been hospitalized at the ward before.

The ward had recently undergone a transformation from an open ward, without the possibility to detain patients against their wish - to a “closed” ward with locked doors and other means of restraints, such as belt-strapping. There was a system of privileges which granted some patients the right to leave the ward, while some were not allowed to do so. The professionals kept track of the rights and restraints of individual patients by writing these down on a large whiteboard in the staff room.

Many professionals described difficulties with the new structure of a secured unit, and complained of the lack of training in handling confrontational situations with patients. They explained that they had only received a quick course in handling conflicts, and wished for more training in handling patients who acted threateningly or violently. They wore a safety alarm, a small white artifact with a button to press. If they sensed they were in danger, they could press the button, and so send a signal to call on colleagues from the surrounding wards. The shift to a closed ward, placed in a new location and offering many new challenges, had also meant that some of their colleagues had resigned or been transferred to another unit. Some professionals said that the new organization and the relocation to a new building far from their homes had made them actively look for other jobs.

The treatment philosophy of the ward requires some closer explanation. The general model was inspired by Open Dialogue and network approaches, a treatment framework originally developed in Western Lapland in Finland. Open Dialogue is a network based, language approach to care, which integrates different therapeutic models (Seikkula & Olson, 2003). In its original form, it draws on a postmodern, social-constructionist framework, with inspirations from Bakhtin and Bateson. The model developed in Finland is based on the principles of tolerating uncertainty, dialogism and polyphony; it takes a critical stance to phenomena otherwise characterized as individual psychopathology, viewing them as a crisis in a network of people (Seikkula & Olson, 2003: 405). It subscribes to a socialconstructionist notion of truth, in that there is no conception of truth or reality outside of the effects of a dialogue (ibid: 410).

The team's application of the Open Dialogue paradigm was selective, and Open Dialogue's potentially radical suggestions seemed to have been downplayed. From what I could tell mostly two practices inspired by Open Dialogue were applied. The first was that of inviting patients and their relatives to a network meeting with a loose agenda. During these meetings each participant would say what was on their mind, in accordance with Open Dialogue. The second practice was the idea of a reflecting team. Two professionals sometimes had a meeting with the patient - and once or twice during the meeting the professionals would turn to each other and reflect openly on what they had heard the patient saying. Many professionals expressed regret that time restraints and workload, however, made it increasingly difficult to find time to carry out this model of meetings.

Other principles of Open Dialogue had not been adopted. A principle which many professionals regretted they were not able to observe for practical reasons, was the principle to establish the first network meeting within 24 hours and to have continuous meetings on a daily basis, if needed. Instead, most patients had one or perhaps two network meetings during their hospitalization. Among the other ideas of Open Dialogue which had been intentionally rejected was the principle to refrain from having meetings or discussions about the patient without the patient present. This principle in Open Dialogue is aimed at a more equal distribution of power and knowledge (Seikkula & Olson, 2003; Seikkula, 2011). The possibility of inviting patients to meetings had been discussed in the team, but it had been dismissed. One nurse

explained this in the following way: If I was having surgery, it would trouble me if I had to listen to the doctors and nurses discussing my case. This choice seemed to result in a more traditional psychiatric hierarchy of knowledge, where the professionals continuously discussed the patients and their problems in their absence.

The ward did not appear to be as preoccupied with implementing the instructions of the Danish Quality Model as the clinic. However, just as in the clinic, many professionals at the ward experienced an increased pressure of workload as well as budget cuts, which meant that many working-shifts were understaffed. On most days, the main structured activity they were able to offer patients was a group walk in the area - and even this activity was sometimes not possible, when a working shift was very understaffed.

Differences, similarities and transferability

If we sum up the most important similarities and differences between the settings the following patterns may be noted. At the clinic, patients lived at home and most had voluntary contact with professionals; at the ward the patients stayed for shorter or longer periods and there was a mixture of voluntary and compulsory treatment. The patients had similar diagnoses at the ward and the clinic, albeit at the ward they were considered to be in a particularly acute period. The patient turnover at the clinic was calmer and many patients had had the same case manager for many years, while at the ward the patients came and went - although some also retained contact to their contact person after discharge in outpatient meetings. In both settings the professionals experienced an increasing workload and time pressure. The professionals at the clinic were on average more experienced and older than those at the ward. A great difference was the amount of interventions offered. The clinic offered a range of different group activities and other psychosocial interventions, and many patients were enrolled in these. At the ward, the group activities were limited to a walk a day (on most days), watching television and sometimes playing a game. From what I observed, no group interventions were offered, and individual psychotherapy was not a part of the standard offers.

Unfortunately, little information is available for a formal appraisal of whether the two settings are comparable to “a typical” Danish mental health clinic and ward, respectably. The descriptions above may allow for some speculation.

The clinic worked with cognitive-behavioral techniques, which are largely becoming the norm in Denmark and it seemed to consider itself rather at par with other mental health clinics. There is therefore little reason to think that the clinic differed greatly from other mental health clinics. Judging about the typicality of the ward is more difficult. In the initial negotiations of access, it had been indicated that the ward was different and more concerned with user involvement than other acute wards. One nurse also told me that the professionals at the ward were known among surrounding wards as radicals or “hippies” who allowed the patients too much influence. Some patients also said they did perceive the ward to be different from others, as they felt the professionals were “nicer” here. However, other patients said they did not experience it as any different from other wards they had stayed in.

There is very little systematized information available about life and daily routines in acute wards in Denmark, but studies from other countries point to a limited level of patient-professional contact, with most patients spending the day alone or with each other in the common room, as well as few activities for patients (Quirk & Lelliott, 2001; Sharac et al., 2010). Studies from Denmark and other countries (e.g. Barrett, 1996; Schepelehn Johansen, 2005) also indicate the centrality of pharmacological treatment approaches. This seemed to reflect everyday life at the ward of study. Careful speculation may therefore show that the ward did perhaps differ from other wards on some measures (e.g. “nicer staff”/more idealistic attitudes), but not on others (e.g. level of patient-professional contact and the centrality of pharmacological treatments).

Methods

Ethnography and participant observation

A central method of producing data for the study was participant observation and situated, ad hoc interviewing. Participant observation was selected as a research method as it was appropriate for fulfilling the research purpose of obtaining a situated understanding of the language and the everyday life of patients and professionals. The observations at the psychiatric facilities were conducted in accordance with the wishes of Region Zealand to obtain knowledge on “how it is talked with, to and about patients” in the institution.

This meant that the fieldwork was conducted without focusing on the efficacy of the treatment or whether the professionals fulfilled the explicit aims of the organization. Instead, I wished to explore what was going on in the facilities, what people talked about, how they talked, and how this was experienced by the people in the field (Ahrenkiel, 2004). The ethnographic approach was therefore appropriate, since, as Emerson, Fretz & Shaw (1995:1) note, ethnography “involves the study of groups of people as they go about their everyday lives” (1995:1).

Ethnography has a long tradition and represents many different schools of thought. The intention of this study was to work with an ethnographic approach that was helpful in answering my research question and that was consistent with the general theoretical and meta-theoretical framework of the study. The ethnographic position I draw on places itself between realist and subjectivist approaches and may be termed *constructionist ethnography*, (Preissle & Grant, 2004). In this tradition it is assumed that the material world exists apart from human consciousness of it; however the meaning of the world is always prescribed by the human mind. In this sense, knowledge is created in the interaction between the researcher and the field. Thus, the process and the product of research are an interaction between the researcher and the outside world. Accordingly, producing a credible account requires an awareness and reflexivity on the subjectivity of the researcher, but the data are still placed in the foreground.

Such an approach has also had implications for my position during the fieldwork. Spradley (1980) lists a continuum to describe the degrees of participation possible for researchers during fieldwork, ranging from nonparticipation to complete participation. On this continuum I shifted between actively participating and passively observing. I did not try to make myself or others believe that I was a neutral “invisible” observer, but neither did I intentionally try to change a course of events. During formal meetings, e.g. patient-professional meetings or staff meetings I remained silent, scribbling away in my notebook on the side. However, during informal meetings, such as lunch breaks at the clinic or while watching television at the ward, I often claimed a more participatory position. As will be elaborated in my analysis of researcher positioning in the first article, my participation approach was quite varied in the two settings. At the clinic, I followed the professionals and was introduced to patients by them. At the ward I followed the patients and largely avoided contact with the professionals in the beginning.

Whenever I had the possibility, I also conducted small informal interviews (DeWalt & DeWalt, 2002) with the participants, following their lead but occasionally asking questions to clarify points or prompt them to keep talking. The informal interviewing was a useful way to obtain information and to learn about the social world of the participants. My degrees of involvement, i.e., what I said and did during each activity, were carefully noted in the field-notes, which will be described next.

Producing the fieldnotes

My fieldnotes were written during periods of observation in formal situations such as a meeting between a professional and a patient, and after periods of observation in informal situations where a pen and paper seemed intruding. In the formal situations, where I could openly write notes, the participants' statements were written almost verbatim.

Regardless of when and where the notes were written, I developed a system for discriminating between direct quotes (in quotation marks), my paraphrasing, descriptions (in normal writing) and my personal reflections (in italic) to improve the reliability of the fieldnotes (Emerson et al., 1995:51). The division was naturally artificial, since observations cannot be recorded without interpretation. However, marking my own reflections in a separate writing style made it easier for me to get closer to my own implicit preconceptions and understandings in the subsequent analytical process. This understanding of my reflections served as a step towards examining my own research positions critically.

In the fieldnotes I concentrated on what was said and done by the participants. I also wrote what the people I met looked like, and how they were placed physically in relation to each other. I noted down if anything puzzled me or gave me an emotional reaction, how I was introduced to patients and professionals, and how people seemed to react to my presence. At both institutions I also sketched the physical appearance of the place, what was written on posters and information sheets on the walls and which type of brochures were placed where. Many of these details, obviously, have not been selected for analysis. However, all my impressions were noted as concretely and "lushly" (Goffman, 1989:131) as possible, in order to try to let as little as possible "slip out of sight", and to later make it easier for myself to (re)create the

scenes and my experiences as vividly as possible when reading the notes (ibid.).

The fieldnotes were initially “jottings” (Emerson et al., 1995) written into extensive fieldnotes on computer later the same day and sometimes the next. This was done following the recommendations by many ethnographic scholars (DeWalt & DeWalt, 2002; Emerson et al., 1995; Goffman, 1989; Spradley, 1980) to keep the observations fresh in memory. All fieldnotes were structured and written in chronological order, starting each day with my arrival to the site and ending with my getting on the train and leaving it.

Daily rhythms and formal observations

Both at the outpatient and inpatient facilities I attempted to follow the daily rhythms of the institution. At the outpatient facility, I arrived in the morning with the staff at 8:30 and I joined the morning meetings at 9 o'clock to 9:30, during which the professionals would discuss formal issues and share information. Usually I scheduled to join between two and four meetings with patients every day and I usually left when the facility closed at 4 o'clock, or half an hour earlier, to catch the train. All in all, I spent 19 days at the clinic.

At the ward I came at different times, but mostly in day hours. I spent three evenings at the ward, until 8 p.m., 9 p.m. and 11 p.m. respectively. In the beginning of my fieldwork at the ward I spent most of the time in the common areas for patients, especially the living room and the activity room. Towards the end of the fieldwork, I also sat in with the staff during their meetings. I participated in all possible common activities when I was at the ward – which usually amounted to a walk a day - and twice we went to play boule and to sit on the grass in the sun. I also played table tennis a few times with patients and once a professional joined us. Altogether I spent 18 days at the ward.

My approach in both settings was to not be selective, but instead to participate in as many activities as possible, to get a broad picture of the types of formal and informal activities that were taking place. I aimed at joining each type of available formal activity available at least once. Below, I present an overview of all the kinds of formal activities I ended up observing. I believe the activities I joined give a relatively comprehensive picture of the types of formal activities available to patients - with the exception of group therapy (only offered at the clinic), which the professionals thought was too sensitive for me to observe.

Formal activity	Observed Instances
Staff meetings/handovers	28
Staff treatment conferences	4
Staff supervision/reflection	2
Patient-staff morning/evening handovers ¹⁷	11
Contact person/case-manager meetings with patients ¹⁸	10
Patient home visits	7
Doctor-patient meetings	6
Sessions of psychoeducation ¹⁹	4
Network meetings	2
Occupational therapy sessions	2
Social worker sessions	2
Psychotherapy sessions	2
Psychiatric evaluation of patients hospitalized in general hospital	2
Syringe injections	2
Distribution of Electroconvulsive Therapy	1

Five of these observations were additionally recorded and transcribed. As most of my time in both settings was spent on unstructured and informal activities, the list gives a very incomplete idea about my fieldwork at the ward. However, it provides an overview of the type of formal situations I observed. Except for the different kinds of staff meetings, I believe the types and frequency of formal activities I observed correspond more or less to the proportions of meetings a typical patient may be invited to. That is, patients would have the most frequent meetings with their contact person or case manager, some meetings with a doctor, sometimes home visits, and perhaps some sessions of occupational therapy or meetings with a social worker. At the clinic, but not at the ward, many would additionally have some sessions of psy-

¹⁷ These were brief meetings at the ward, during which a professionals would inform patients about who were their contact persons for the day, the planned activities for the day and the patients could bring up AOB.

¹⁸ Case managers/contact persons were either nurses, health care assistants or occupational therapists

¹⁹ Psychoeducation, i.e. patient education about their diagnoses was either in a group or individual format. It was reminiscent of a classroom situation, in which a professional would make use of PowerPoint slides to teach and head discussions about symptoms, aetiology and prognosis.

choeducation or other group activities. In both settings, but particularly at the ward, only a few selected patients were invited to individual psychotherapy (although many expressed such a wish), and consequently psychotherapy is not very present in the data.

In the final analysis, I have clearly not made use of all the notes from the meetings I observed. During the fieldwork I joined as many activities as possible in an open manner, and had few preconceptions of what may be important for the final analysis. During the analytical process, as my knowledge of the data, the field and the research focus became more precise, I selected for analysis the cases and extracts which were the most relevant for my analytical interests. In this way, I have not sought to reach an even distribution of all types of activities in the data extracts in the final analysis, but instead I have let my particular analytical attention and the analytical procedure guide the selection of extracts. Since most of my notes of formal patient-professional meetings are derived from case manager or contact person meetings with patients, many of the extracts I make use of in the analysis are from these types of meetings, which are also the most frequent types of meeting a patient would attend.

Interviews with patients and professionals

Apart from the situated informal interviews conducted during the participant observation, the data set also consisted of recorded semi-structured interviews. For this purpose, I developed one interview guide for patients and one for professionals, based on the research questions of the study and my observations in the field (cf. Appendix 4 and 5).

In recruiting patients for interviews in both settings my interest was mainly directed towards people who had somehow stood out in the talks among the professionals. Since my focus was on understanding contradictions and tensions, I wished to focus on patients who were described as “difficult” or “complex”. In order to contrast the experiences of the “difficult patients” and to strive for maximum variation within the data set (Polkinghorne, 2005) I further strived to interview patients who were described as particularly co-operative by professionals.

Altogether, I interviewed 13 patients, at least four who had been explicitly pointed out by professionals as particularly difficult to work with - and at

least four who were pointed out as particularly well-liked and easy to work with. Seven patients were in voluntary treatment, four in involuntary and two were presently in voluntary treatment, but had previously received involuntary treatment. To preserve anonymity, I present further information on patients in a cluster.

Gender	Age	Length of contact to MHS	Diagnoses
<ul style="list-style-type: none"> • 6 women • 7 men 	Range: 21-48 yrs. Mean: 33 yrs. (SD=10) <ul style="list-style-type: none"> • In 20's: 5 • In 30's: 2 • In 40's: 6 	Range: First hospitalization-20 years Mean: 9, 3 yrs. (SD=5, 9). <ul style="list-style-type: none"> • First hospitalization: 1 • 1-5 yrs.: 4 • ≥ 10 yrs.: 8 	<ul style="list-style-type: none"> • Schizophrenia/paranoid schizophrenia: 5 • Borderline personality disorder: 1 • Borderline personality disorder paired with other diagnoses (e.g. ADD, depression, schizophrenia): 3 • Obsessive-compulsive disorder: 1 • Depression: 1 • Generalized anxiety: 1 • Bipolar disorder: 1²⁰

In the interviews with professionals I aimed at including professionals who were positioned differently within the organization (Staunæs & Søndergaard, 2005:55). I thus interviewed at least one professional from each professional group in the interdisciplinary teams. This was to make sure that the study had access to different perspectives and views on psychiatric work. At the clinic I interviewed 7 professionals, at the ward 4. Below I present characteristics on the professionals, again in a cluster to preserve anonymity.

Gender	Profession	Age	Length of professional experience	Years of working in the team
<ul style="list-style-type: none"> • 9 women • 2 men 	<ul style="list-style-type: none"> • 2 nurses • 3 health care assistants • 2 occupational 	Range: 28-63 yrs. Mean:48 yrs. (SD=11.5) <ul style="list-style-type: none"> • In 20's: 1 	Range: 2-40 yrs. Mean:16,8 yrs. (SD= 12,8) <ul style="list-style-type: none"> • 1-5 yrs.: 1 	Range: 1-24 yrs. Mean:6,1 yrs. (SD=6,3) <ul style="list-style-type: none"> • 1-5 yrs.: 1

²⁰ The ICD-10 diagnostic criteria for the most common diagnostic categories in the settings, psychosis and schizophrenia as well emotionally unstable personality disorder, borderline type, are found in Appendix 7.

	therapist • 2 doctors • 1 Social worker • 1 Psychologist	• In 30's: 2 • In 40's: 2 • In 50's: 4 • In 60's: 2	4 • ≥10 yrs.: 7	8 • ≥5 yrs.: 3
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The table can be said to more or less represent the staffing of a typical mental health team in general psychiatry. Usually nurses and health care assistants make up the largest professional groups in a team. Additionally a team will typically have one or two physicians, an occupational therapist and a social worker. Usually a team will also have an affiliated psychologist who may, however, sometimes share his or her time between different teams. Furthermore, the gender make up is also quite typical for a mental health team – there are usually more women and few men.

All interviews lasted between 30 minutes to two hours. At the outpatient clinic most interviews were conducted at the facility. Based on their wishes, one patient interview was conducted in the person’s home and one was conducted at the public library in town. At the ward four interviews with patients were conducted in their rooms. At the request of the participant, one interview was conducted upstairs from the ward, and another was conducted in another ward that a participant had been moved to. The interviews with professionals either took place in the common professional office, in the professional’s own office, or in a secluded conversation space. All interviews were transcribed (cf. appendix 6). The final interviews and fieldnote extracts in the analysis were translated from Danish to English.

Because some of the professionals (e.g. social worker, occupational therapist and psychologist) were only represented by a single individual in the team, to preserve their anonymity at times I refer to professionals as just “team member”, “case manager”, or “contact person” in the final analysis without specifying their professions.

The interview guides

In designing and developing the interview guides (Appendix 4 and 5), I wished for the questions to be both thematically relevant, so they could help answer the study’s research questions, and to function in the interviews on a dynamic inter-human level (Kvale & Brinkmann, 2009). My objective with the interviews was to understand what the informants thought important

about their experiences in psychiatry, and how they ascribed meaning to their role in the mental health services.

In the first part of the interview, the patients were asked about their life before entering psychiatry. I asked open questions such as: “Can you tell me a little about your life before you came in touch with psychiatry?” “Can you tell me about what happened when you got in touch with psychiatry for the first time?” This part of the interview had the purpose of developing the participants’ self-narratives, their experiences earlier in life and the personal meanings associated with entering psychiatry (Chase, 1995). The second part of the interview was about the person’s relationship to psychiatry and how they experienced their life as psychiatric patients. They were asked about particular events that had been important to them; and what made these events important. They were asked whether entering psychiatry had changed their understandings of who they were. The final part of the interview specifically addressed their experiences of participation and service-user involvement. Here, they were asked whether they felt they were listened to in the mental health services and how they experienced their possibility of influencing decisions.

In the interviews with professionals, my focus was on understanding how they regarded their work and how they ascribed meaning to working with patients. The first part of the interview concerned how the professionals regarded their role in the mental health services. They were asked what made them choose the mental health field, and what they enjoyed the most and the least about their work. The second part was about whether their work and psychiatry had changed since they started working, and how they had experienced those change. Finally, they were asked specifically about how they understood user involvement and whether it was something they thought about in their work. With most professionals, I was additionally able to ask them about specific patients that I had observed them with and about specific meetings with these patients. I wished to get their understandings of the situations I had observed, and wanted to hear their reflections about what made the specific patient difficult or easy to work with.

In the beginning of the study, apart from participant observations and interviews, I additionally had an idea that I would explore the written language of psychiatric records, and I asked patients I interviewed for their consent for my access to their medical files (Appendix 3). However, I have made limited use of the records in the final analysis. This is not to say that an additional

analysis of the written language would not have been interesting, but rather that time and space restraints made it difficult for me to incorporate such an analysis. There is already a substantial amount of work dedicated to the written language of psychiatric records (Barrett, 1988; N Buus, 2009; Hanganu-Bresch & Berkenkotter, 2012; Swartz, 2005, 2006) that the reader may find interesting. While drafting the first sketches for the analysis, I found that the contribution of this thesis would be more substantial if I focused my analytical attention to the spoken language and actions that took place in meetings between professionals and patients.

Analytic procedure

The discourse theorist Ian Parker (1999:3) has noted that an analysis of discourse of clinical practice needs to be both respectful and critical. On the one hand it needs to do justice to the stories people tell about their distress, the experiences they have of living with it. On the other hand, it needs to be critical and acknowledge that therapeutic practices often are embedded in images of the self and others that may themselves contribute to the experienced problems. Parker writes mostly about the dialectic of being critical and respectful about the experiences of patients. I would add that in this thesis the criticism/respect must also extend to the work of psychiatric professionals. As the medical sociologist Nick Fox (1995) has noted, there is a tendency within critical health research to undermine the work of professionals and to see them solely as instruments of power. In the analytical process I have attempted to balance the dialectic of being critical and respectful in two main ways. Firstly, the critique that I strive to develop is not to be understood as passing a negative judgment, but rather as a curious stance which questions taken for granted assumptions. As Foucault writes:

“A critique does not consist in saying that things aren’t good the way they are. It consists in seeing on just what type of assumptions, of familiar notions, of established and unexamined ways of thinking the accepted practices are based...To do criticism is to make harder those acts which are now too easy.” (Foucault, 2003a: 172)

The way I have explored taken for granted assumptions is by being specifically concerned with points of conflict and dilemmas in the field. Thus, in my analytical attention I have been especially attentive to circumstances and situations that have involved a dilemma or conflict. From this perspective, ana-

lyzing what is considered problematic, different, or a breach of norms allows for an optic of what is considered the norm: e.g. “normal patients” or “normal patient-professional relationships”. Because the norm is often taken for granted and may become invisible, looking at what is produced as problematic can work as a mirror to what is considered normal (Holen & Lehn-Christiansen, 2010; Søndergaard, 2005).

The second way I have strived to analyze the data with a critical and respectful perspective, is to attempt to give both patients and professionals “a voice”. In order to develop an analytical strategy which is both critical and respectful, I have read the empirical data at three different stages and from three different angles, as reflected in the structure of the analysis.

My *first* systematic engagement with the data was from the perspective of researcher, during which I especially looked at the dilemmas I encountered in interactions with patients and professionals during the time of fieldwork. This reading resulted in the first article of the analysis. My *second* systematic engagement with the data was approached from the angle of patients; I was especially concerned with the dilemmas they were facing and I tried to imagine how they experienced the discourses which positioned them in different ways. This reading resulted in the second article, on illness constructions and their implications for patients. My *third* systematic engagement with the data was approached from the angle of professionals. I looked specifically at the difficulties and dilemmas they were facing and tried to imagine how these were experienced.

Concretely, I have worked at every stage of the process by locating themes in the data. This was an open process, which was neither deductive in the sense of aiming to test previous hypotheses, nor entirely inductive since my epistemological and ontological assumptions guided my attention. Below, I describe the concrete analytical tools I have made use of.

Initial Thematic Analysis

I had help from a friend who acted as research assistant in transcribing some of the interviews and we discussed initial ideas in the process. While transcribing, she had many interesting thoughts and I encouraged her to write them down. In this way I both had my own notes as well as hers, when I read the interviews and fieldnotes. In the process of classifications and thematiza-

tions I made use of the version of thematic analysis developed by Braun & Clarke (Braun & Clarke, 2006). I looked at and thematized the data altogether, starting with the patient interviews and then moving on to the fieldnotes, and finally the interviews with professionals. Braun and Clarke map out different stages for developing themes when working with text data. Briefly, these stages are:

1. *Familiarization with the data.* I began the process of analysis by repeatedly reading and re-reading the fieldnotes and interview transcripts, while making small comments to myself. This is the common procedure for creating in-depth familiarity with the empirical material in qualitative research.

2. *Generating initial codes.* At this stage the researcher unselectively codes as many themes as possible in the text. I did this mostly by ways of summing up what was in the data. I also made more interpretative and theoretical claims, marking these as NTM (notes to myself).

Below is an example of a text extract with my codes. The example is taken from the first interview that I coded and so it is more detailed than the later processes of coding; as I worked on with the coding and started getting an overview of general themes, the coding became less detailed. However the general technique was similar throughout the process.

Text	Preliminary codes
<p>F: I had to get out of psychiatry, I was thinking [smiles] I was part of this huge game, you could call it, um, at the time (mm) and (.)</p> <p>A: Game?</p> <p>F: A game, sort of (yeah?) a mind game, god, Satan, something like that (.) um, which was going on at the time (.) um, s-, I was on a little mission, or what to say. And then I just had to get out of it [psychiatry] as much as possible, so I lied like crazily much about how I was doing, and, kind of to (.) avoid taking medication and (.) to avoid all that stuff</p> <p>A: Mm, what did you say?</p> <p>F: Well, I can't almost, I can't really remember it, I mean it's really "blurred" [in English] in a way,</p>	<p>Characterization of first hospitalization</p> <ul style="list-style-type: none"> - Being part of "a mission" - Being in a "a game" (god Satan) (metaphors) - Lying as a strategy to leave MHS and avoid medication - Trouble remembering the first hospitalization: "Blurred", "Black and white" <p>[NTM: unusual metaphor – black and white, used differ-</p>

<p>totally black and white (7s.) yeah</p> <p>A: But was it stuff like that you were doing fine, or?</p> <p>F: Yeah, I was doing fine, in a way (.) I just didn't really get much of it (.) I didn't get much of what was going on (no?) Um, of the world, and yeah, just generally. Um, and then after that I just kind of got a little caught by (.) by voices and thoughts and (.) stuff like that which almost closed me in my room for a year or something (.) so. I couldn't really get on from that (mm), or I am now, but it took some time, you could say.</p> <p>A: So you stayed in your room for a year?</p> <p>F: Yeah and just listened to this stuff, that (.) almost massacred me, or what to call it.</p>	<p>ently in other parts of interview]</p> <p>[Researcher position: Misunderstanding between A. and M?]</p> <p>“Was fine” (triggered by A's question?)</p> <ul style="list-style-type: none"> - Confusion - Confinement as an action of the voices and thoughts: caught by voices and thoughts, which <i>closed me in my room</i> for almost a year <p>[NTM: discursive self-construction as non-agent, voices and thoughts as agents]</p> <ul style="list-style-type: none"> - Moving on as time consuming - Voices “almost massacred me” – non-agentic construction of person <p>[NTM: interestingly, agency is present in most of the narrative but when talking about the distress, agency seems to disappear]</p>
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The end product of this stage was a long list of codes and potential themes.

The next stage, stage 3, involved *Searching for themes* across the codes. At this stage, I started to look for patterns across themes such as overlaps, similarities, differences, overarching themes and subordinate themes. In this process, I distanced myself from the initial data to focus my attention on the codes which have been generated. The result of this stage was a long, crude list of themes:

- RESEARCHER POSITIONING
- ILLNESS DEFINITIONS
- PATIENTS' SELF CONSTRUCTIONS
- PATIENT IMPERATIVES AND NORMS
- PATIENT STRATEGIES FOR MANAGING MHS
- PATIENTS' RESISTANCE
- OBJECTIFICATION
- SUSPICION
- PATIENT-PROFESSIONAL RELATIONSHIPS
- PROFESSIONAL RELATIONS AND PROFESSIONALISM
- PROFESSIONALS' STRATEGIES FOR MANAGING MHS
- PROFESSIONALS' RESISTANCE

- POWER AND CONTROL
- ETHICS
- VALUES ON WHAT CONSTITUTES GOOD PSYCHIATRIC TREATMENT
- USER INVOLVEMENT
- NEOLIBERAL TRENDS
- CONDITIONS AND STRUCTURES
- MEDICATION

In the next stage, stage 4, I *reviewed the themes* and restructured them. At this stage I skimmed the original data and my themes to see if I could identify overlapping themes, overarching themes and sub-themes to synthesize the many disparaging themes. In this process many themes were grouped together and re-arranged as some turned out to be overlapping, others turned out to be overarching and yet others became sub-themes.

Among the themes that were grouped together were: patients' strategies for managing MHS, patients' resistance, patient self-constructions, patient imperatives, illness definitions, objectification and suspicion – these were grouped into the overarching theme that became the main topic for article 2: *constructions of mental illness and patient identities*. The other themes that were grouped together were: professional relations and professionalism, patient-professional relationships, power and control, professionals' strategies for managing MHS, professionals' resistance, ethics, values on what constitutes good psychiatric treatment and user involvement – these were assembled under the overarching theme that became the topic for article 3: *patient-professional relationships and user involvement*. The theme *researcher positioning* became a main theme itself, and developed into the outline for article 1: on *researcher positioning*. Finally, the themes on conditions and structures, medication and neoliberal trends turned out not to be independent themes in themselves, but were divided into different sub-themes that were sorted under the other main headings. In this way, I ended up with three general themes, each of which provided the outline for an article:

- RESEARCHER POSITIONING AND ITS MEANING (Article 1)
- CONSTRUCTIONS OF MENTAL ILLNESS AND PATIENT IDENTITIES (Article 2)
- PATIENT-PROFESSIONAL RELATIONSHIPS AND INVOLVEMENT (Article 3)

Some poststructuralists have questioned the extent to which coding is fit for capturing the richness of empirical data in qualitative research. For instance,

Brian Massumi (2002) has argued that coding necessarily constitutes a “stop-operation” which freezes the text - and thus fails to grasp fluctuations, processes, movements and change. According to him, structure and orderliness are forced on to the text by the researcher, who creates neat and applicable structures which cut narratives into pieces and reduces the “messiness” of reality.

The criticism is not unwarranted; there inevitably is a loss involved in the process of coding - with the greatest challenge perhaps being grasping complex speech acts such as irony and jokes. At the same time it can be argued that any analysis must to a certain extent reduce complexities and simplify the world in order to arrive at specific conclusions (MacLure, 2011). Moreover, as I have argued before (Chapter 5), there may be a tendency in some poststructuralist work to overemphasize fluctuations, instability and change, for example when it comes to identity formation and self-understandings. The same argument may be made concerning the issue of coding and analysis. Language, apart from being changeable and dynamic, also does incorporate certain stability. Working with language data, then, entails both elements of stability and movement (MacLure, 2011).

Coding has the additional strength of involving a long process of engagement with the text and familiarization with the data. It therefore allows the researcher to have a detailed knowledge of the data, enabling a detailed and specific analysis to emerge. Moreover, the process of coding makes it possible for the researcher to distance herself from the text - allowing for reflexivity to arise (MacLure, 2011). Thus, although coding may not be an ideal tool, it is a way of working with the text which entails many strengths.

Asking questions from Foucauldian Discourse Analysis

Having categorized the different codes and having arrived at the stage of writing the analysis, I found inspiration in the questions asked by the version of Foucauldian Discourse Analysis developed by Carla Willig (2008). Willig's (2000) work is especially concerned with developing an understanding of the relationship between discourse, experience and subjectivity. She outlines six general themes, with a number of questions each, for conducting a discourse analysis in the Foucauldian tradition.

The first sets of questions concern *discursive constructions* and *discourses*. They ask: How is the discursive object constructed through language? What discourses are drawn upon? What are their relationships to one another?

Subsequently, the analyst asks questions about *action orientation* and *positioning*. What do the constructions achieve? What is gained from using that particular construction here? Which subject positions are made available through the constructions?

Finally, the researcher asks questions concerning *practice* and *subjectivity*: What possibilities for action are mapped out by the constructions? What can be said and done from within the subject positions? What can potentially be felt, thought and experienced from the subject positions?

I have employed these questions to guide my interpretation of concrete data examples - and with each extract in the analysis I have allowed the questions to open up new interpretations. At different stages in the process of writing the articles I have made small drafts where all six sets of questions were raised and explored in the form of bullet points. Naturally, not all points from these drafts have found their way to the final analysis. With most extracts in the analysis, some questions rather than others have been emphasized. For instance, in one particular extract I may have been especially interested in positioning, in another in discourses and yet in another in the implications for practice or subjectivity. In this way I have used Willig's model as an inspiration for developing interpretational sensitivity, rather than actually structuring the final text according to it.

Ethical considerations

Since the study took place in a psychiatric setting, I start by briefly outlining the formal ethics that apply to research in such a setting and how I met these demands. I then move on to a discussion of my ethical considerations throughout the research process.

Formal ethics

Prior to the fieldwork I gained approval for conducting the study by the *Danish Data Protection Agency* (Datatilsynet), under the umbrella approval that ap-

plied to the psychiatric research unit of Region Zealand. I also contacted a representative from the *The National Committee on Health Research Ethics* (Den Nationale Videnskabetiske komité), and was informed that it was not necessary to apply to them, because the study did not make use of biological material nor did it involve a planned intervention.

The initial consent for conducting the study was provided by the management of each setting. Upon entering the settings I first held meetings with the professionals during which I informed them about the purpose and design of the study. I also made it explicit that anyone who did not wish to participate could decline. I provided written information on the study (cf. Appendix 1) and I made sure that it was available at all times during the fieldwork. Before observing each patient-professional meeting I also obtained verbal consent from both parties. If one of the parties disagreed (which happened a few times in each setting), naturally I accepted this decision. At the outpatient ward, the process of consent was less straightforward. The professionals had consented to have me present, but, as such, the patients were not given a direct choice if they wanted to have me present at the ward. Instead, a week before the beginning of the field work I hung a poster on the ward (Appendix 2) on which I informed about the study and stated that anyone who wished to could decline participation. On my first day of the fieldwork, I presented the study during the morning meeting and repeated that participation was voluntary, and that if anyone wished not to be part of the study I would not write about them. None of the patients made use of this option.

Prior to each interview I explained how the interview would precede, the types of questions that I would ask and I informed each participant that they could decline to reply to a question that they did not wish to answer. I also told each participant that participation in the interview was voluntary and that if they regretted their participation after the interview they could contact me any time and withdraw their consent.

The interviews with the professionals were based on their verbal consent. For the interviews with patients, I asked for both verbal and written consent (Appendix 3). Additionally, I asked them if they wished to sign a consent form for access to their patient files for me to analyze written language about them. However, as discussed, I have made limited use of the patient files in the final analysis.

All the data were kept locked up in an anonymous form according to the standards of the Danish Data Protection Agency and I used an encryption program (*TrueCrypt*) for working on the data on my computer. The names of the settings as well as all the participants have been made anonymous and confidential personal information which may compromise anonymity has been changed. To further distort the possibility of recognizing individuals, I have at times varied my use of pseudonyms when citing or referring to the same person: i.e. a person in reality named X may in one example be referred to as Y, in another example as Z, and yet in another as W.

Instrumentality and “faking friendships”

A procedural, checklist type, of approach to research ethics may lead a researcher to believe that once she has fulfilled the formal ethical requirements, the research is intrinsically ethical or risk-free (Brinkmann & Kvale, 2006). Instead, I consider the question of research ethics to be an on-going critical reflection that needs to be addressed at all stages of research. Below I outline some ethical reflections concerning my interactions with the research participants and the consequences of the study.

I cannot say if all participants were happy to have me present. This was perhaps less of a dilemma during the formal observations of patient-professional meetings, during which I always asked for both the professional's and the patient's consent - but more of a problem during the informal participation during morning meetings, in the office with the professionals, or while watching television or smoking with patients at the ward. Many ethnographers have written about the nuisance participants may experience by having a researcher observe them (e.g. Wind, 2008) and this, I imagine, was also sometimes the case in this study. I strived to accommodate this by spending a lot of time “hanging out” without obviously recording observations, but attempting to naturally take part in discussions and activities.

Brinkmann & Kvale (2006) have written about the concealed forms of power inherent in modern, qualitative research interviews, which stress warmth and empathy in the interview situation. They warn about the dangers of applying therapeutic techniques, which lure the participant into revealing personal information that will later be used instrumentally by the researcher. Especially in interviews with patients, I was aware of the risk of the research interview resembling a psychotherapeutic session and I tried to differ from a patient-

professional interaction, e.g. by bringing sweets to the interviews, and also by telling them details about myself. For some, however, I believe, the possibility to talk about their experiences and their life history to someone who mostly listened, may have resembled psychotherapy. Some patients asked me about my professional background or otherwise found out that I was a psychologist (cf. first article). One patient, who had asked about my education as a psychologist by education, asked if I would like to become his psychotherapist after the interview. For ethical reasons I declined his offer.

Brinkmann & Kvale (2006) point out the unethical aspects in the researcher “faking friendships” by simulating personal closeness to the participants. They remind us that the fieldwork relationship is inescapably an instrumental relationship, which is time-limited and serves the researcher’s end of generating new knowledge; it is not a goal in itself. This served as an important reflection for me throughout the fieldwork. At the same time, as Angrosino & Mays de Pérez (2000: 694) have pointed out, the idea that one can predict, and thereby avoid all possible harm in research is deceptive. Just like in any other human interaction, it is impossible to know all the elements and possible outcomes beforehand.

Being in an institution in which many of the participants experienced much emotional distress and often seemed grateful to share their experiences, it was difficult to avoid emotional attachments to research participants and perhaps vice versa. I could only apply a type of trial-and-error learning, in which I attempted to correct or omit problems and dilemmatic situations to the extent possible, once they were occurring (Angrosino & Mays de Pérez, 2000).

Who is made vulnerable by the research? Consequences of the study

Apart from reflections associated with the participant observations and interviews, my ethical reflections have considered possible consequences associated with the publication of the study. The Norwegian ethnographers Oeye, Bjelland & Skorpen (2007) have pointed out that the common criteria for ethics and vulnerability in psychiatric research are built on a bio-medical model. According to the model, psychiatric patients are considered an especially vulnerable group due to their biological impairment (the mental illness), which is thought to impair their decision making and reasoning. Much discussion in psychiatric research therefore concerns how patients’ impairment may

constrain or influence them in making decisions about participating in research projects. Because of this construction of psychiatric patients, the researcher is often expected to cooperate with the medical staff in charge when deciding on which patients to ask for consent for observation and interviews, and to be especially cautious when interacting with this group. Oeye, Bjelland & Skorpen (2007) argue that this is a simplified and decontextualized approach to research ethics, inapplicable to social research and participant observation. They argue instead that defining a person or group as vulnerable should always depend on the research objective and the context of the research.

Although I acknowledge that my study could possibly have an impact on patients, I believe there is potentially more at stake for the professionals than for the patients. The participant observation I have conducted could produce vulnerabilities and hurt professional identity, since the design of the study scrutinizes how the professionals talk to, with and about patients. My analysis can therefore possibly lead the professionals to feel exposed and misunderstood, or to see themselves in ways they do not feel are attractive. For this study, then, considering the patients as an especially vulnerable group *per se* is not fruitful, as different issues may be at stake for different participants (Oeye et al., 2007). The awareness of such potential harm has encouraged me to try to make the analysis as nuanced as possible and to acknowledge the difficulties that the professionals face in their everyday work. Although I have tried to show in my analysis how the professionals are not free to act as they please - that when they say things or do things which may be experienced as harmful by patients, this is associated with norms that make some decisions more feasible than others - I cannot be sure how the thesis will be read and interpreted.

The fact that access was negotiated through a top-down process, and the management is familiar with the particular settings in which the fieldwork took place complicates the question of anonymity. I have done what was possible, changed names, professions and other personal information such as gender, so as not to reveal individuals, but the fact that the particular research settings were familiar to the management could not be changed. In any study, it is impossible to predict the exact consequences it will have - how the study will be received and used (Angrosino & Mays de Pérez, 2000). One particular risk associated with this constraint on anonymity is that, although I have aimed to show how the participants actions relate to broader institutional and

cultural rationales, the criticism that I raise may be interpreted as concerning only specific individual professionals. I sincerely hope, however, that my analyses instead will be interpreted in terms of institutional and cultural expectation that concern the whole system of mental health – and that they therefore will give rise to broader reflexivity.

Chapter 6: Articles

1. Ringer, A. (2013). Researcher-participant positioning and the discursive work of categories: Experiences from fieldwork in the mental health services. *Qualitative Studies*, 4(1), 1-20 (*published*)
2. Ringer, A. & Holen, M.* “Hell no, they’ll think you’re mad as a hatter”: Illness discourses and their implications for patients in mental health practice. (*Submitted to Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*).
3. Ringer, A. “I would like to maintain your compulsory treatment, is that alright with you?”: Discursive constraints and possibilities for user involvement in day-to-day mental health work (*soon to be submitted in an abridged version*)

* Contribution of co-author: The first author has done the ground work and most of the writing. Mari has contributed with constructive ideas throughout the process of writing and she has elaborated the written drafts that I have initiated.

Article 1: Researcher-participant positioning and the discursive work of categories: Experiences from fieldwork in the mental health services

Abstract

This paper reports on methodological experiences from an ethnographic study in psychiatric institutions in Denmark. Drawing on a poststructural framework and newer discussions within qualitative research that view meth-

odological problems as sources of data, the paper analyzes how the challenges encountered in the fieldwork were indicative of discursive norms within the mental health services. It is argued that the multiple ways the researcher was positioned by participants revealed that the categories “patient” and “staff” were produced as polarized binaries with little leverage for negotiating positions in between. At the same time, it is shown that the patients find ways to resist the objectifying practices of the researcher as well as of the mental health services. The conclusions are discussed against recent attempts within the mental health services to promote a more patient-centered approach and involve patients in the treatment.

Keywords: qualitative methods, researcher positioning, field relations, ethnography, mental health

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Introduction

In this paper I analyze methodological experiences from an ethnographic study on mental health institutions. The study focused on language within the mental health services – on how patients are talked to, with and about in psychiatric treatment. The mental health services of the Danish Region Zealand initiated the study, based on a wish to promote a patient-centered approach and service user involvement. They were interested in the ability of the language used in communication with patients to either restrict or promote involving patients in the treatment. Thus, I was present at two psychiatric institutions with the purpose of producing data on language and service user involvement within mental health care.

The first institution in which the fieldwork took place was an outpatient clinic where patients lived at home and had regular or sporadic contact with the professionals. The second was a secured inpatient ward, where patients stayed for shorter or longer periods of time behind locked doors – but, by proving that they were well enough, could leave the grounds of the ward unsuper-

vised. These two sites were chosen as they represent very different modes of organization within psychiatry. The first is for patients who are considered well enough to live at home, typically with voluntary contact to the mental health services. The other is for patients who are often considered too ill to even go for a walk alone - and are frequently sectioned or admitted on an involuntary basis. Three months were spent on participant observations of the everyday practices within the institutions - such as patient-professional meetings, therapeutic sessions, staff meetings, and treatment conferences. I also interviewed 13 patients and 11 members of staff.

As the study progressed, it increasingly came to focus on language, not just as immediate communication between patients and professionals, but as naturalized forms of wider discourses that restrict and open up possibilities for how it was possible to define and think about patients in the mental health services (Foucault, 1991c, 2005; Holen, 2011; Speed, 2011). Thus, a poststructural framework became the framework for analysis. Such a framework attempts to look beyond the participants' immediate understandings of themselves and the world to analyze the discursive norms and repertoires that participants draw on when they talk. What is said in a meeting between a nurse and a patient, for instance, is regarded as a system of representations that reflects wider systems of meaning within the institution of psychiatry and within society (Speed, 2011). The language used may therefore be said to draw on and construct discursive norms that create and restrict possibilities of defining who patients and professionals are. From this perspective, the discourses and norms available also set conditions that define who the researcher can be, since the researcher temporarily inhabits a part of the social worlds of the participants.

The paper focuses on the methodological challenges that I encountered during the fieldwork, particularly related to how the research participants reacted to and positioned the researcher. Drawing on newer debates that view methodological problems as sources of data, (Angrosino & Mays de Pérez, 2000; Hastrup, 2010; Jensen, 2009; Järvinen & Mik-Meyer, 2005; Savvakis & Tzanakis, 2004), the paper proposes that by analyzing the positions that become available for the researcher in interactions with participants, it is possible to gain important insights on the features of the field under study. This type of understanding transcends the traditional division between methods and research outcomes in that it does not regard interactions with participants

and methodological dilemmas solely as issues of method, but sees them as a point of departure for analysis. The paper specifically analyzes what the mutual processes of researcher positioning indicate in terms of the discursive norms of the institution of psychiatry. The cases used in the paper have all been selected as they are indicative of many dilemmatic situations in which the researcher's position became entangled in the web of the discourses of the institution.

Researcher positioning as a starting point for analysis

It is often stated as a goal that the ethnographic researcher finds a credible place for herself within the structures of the field she is entering; a position that provides opportunities for building trust and rapport so that she may be invited into different activities. Traditional discussions have been concerned with how the researcher may establish the best "role" in the field (Snow, Benford, & Anderson, 1986; see also Harrington, 2003 for an overview). The researcher is often thought to be able to take on roles initially when engaging with participants and stick to them throughout the research process. Problems with establishing a role, or with confusing roles, may be construed as problems of the individual researcher's method. However, newer debates within qualitative research argue that ethnographic researchers cannot unilaterally choose or control roles and options during fieldwork, no matter how carefully they have planned their studies (Harrington, 2003; Preissle & Grant, 2004). Research participants are active in accepting, refusing or re-negotiating a researcher's identity claims. Furthermore, participants rarely perceive the researcher as a unique and decontextualized individual, but define the researcher in terms of categories and norms that pre-exist in the field (Angrosino & Mays de Pérez, 2000; Harrington, 2003). This is why the ways the researcher is understood by participants and the negotiations of access that the researcher encounters in the course of fieldwork may constitute an index to qualities, norms and structures in the social world of participants (Savvakis & Tzanakis, 2004).

The question of the position of the researcher seems to pose a particular problem in qualitative research within health institutions. Van der Geest & Sarkodie (1998: 1375) note: "[qualitative researchers] in a hospital or clinic

find themselves out of place. Not being a doctor, nurse or other type of health worker and not being a patient either makes their position somewhat awkward". Perhaps due to this reason, ethnographic research in mental health institutions in the past has sometimes been conducted covertly, with the researcher masquerading as a patient (Caudill, 1958; Rosenhan, 1973). Nowadays it is more common for researchers in health institutions to engage in overt research, dressing like, and following professionals (Barrett, 1996; Buus, 2005; Grigg et al., 2004; Holen, 2011; Johansen, 2005; Lester, 2009; Søndergaard, 2009; Warren, 1983; Weiss, 1993) - and thereby not infrequently be positioned as a member of staff by both professionals and patients. Many qualitative researchers in health institutions report on dilemmas associated with researcher positioning; however, the analytical implications of either being positioned as a patient or as a professional by the participants in the field are rarely discussed (van der Geest & Finkler, 2004; Wind, 2008). At the same time, when different researchers in diverse times and settings have encountered similar challenges, it is unlikely that the dilemmas can solely be attributed to questions of methods or individual characteristics among the researchers (Jensen, 2009). Rather, they may be considered a starting point for understanding some structural qualities of the research field.

Taking these debates as points of departure, the paper applies the concept "positioning", derived from Bronwyn Davies and Rom Harré (1990) and Harré & Van Langenhove (1999), to analyze the researcher - participant relationship as a meeting between positions. Positioning may be understood as mutual negotiations of social positions that occur when people engage in conversation. When people position each other, they are assigning rights and duties of speaking and acting, based on pre-existing categories, metaphors and discourses (Harré & van Langenhove, 1999). Positioning, therefore, always draws on wider discourses and norms, which are inseparable from the context of the interaction. At the same time, people can exercise notional choice; they can draw on a repertoire of multiple and even contradictory discourses in their self-and-other positioning. People are therefore active when they position themselves and others, but at the same time the amount of available discourses sets the parameters of possible positions. Analyzing the processes of positioning that take place between researcher and participants may thus open up an understanding of the categories and discursive norms that are prevalent in the field and how they operate. In this way, a poststruc-

tural approach to the field relationship can be helpful in unpacking aspects of the field.

I will now turn to look at the positioning processes I became a part of during the fieldwork in the psychiatric institutions and how these can be understood as indicative of the discursive norms that operate in the mental health services. I begin by looking at the outpatient clinic. Because I was introduced to the clinic by the professionals and followed them to meetings with patients, I firstly discuss the positioning process I entered into with the professionals. I then move on to discuss how the frequent interaction with the professionals contributed to positioning me as a member of staff in the eyes of some patients. I look closely at an interview with a patient at the clinic and analyze how the ways I was positioned in the interview provided clues on the discursive norms that operate for patients. Subsequently I turn to look at the positioning processes I became a part of in the other setting of the fieldwork, the inpatient ward. I discuss how I strived to distance myself from a position as part of staff and I analyze the positioning processes I entered with the patients at the ward. Finally, I look at how the professionals at the ward reacted to me and the position of “least staff” that I strived to reach. In the conclusion I relate the discursive norms that emerged in the researcher positioning processes to the question of involving patients and their perspective in mental health care.

First field: Researcher positioning at an outpatient psychiatric clinic

In preparation for the entry to the fieldwork in the first institution, the outpatient clinic, I emphasized my clinical background as a psychologist and the study's affiliation with the mental health services in meetings with the professionals. The intention was that this might facilitate access (Grigg et al., 2004) and minimize the potential threat that being a complete stranger to psychiatric work may pose (Savvakis & Tzanakis, 2004). Ethnographic literature in general encourages researchers to make themselves seem familiar and to find common grounds with the participants in order to “fit in” (Borbasi, Jackson, & Wilkes, 2005; Glesne & Peshkin, 1992; Hammersley & Atkins, 2010; Harrington, 2003; Jorgensen, 1989). I wore a name tag with the logo of the mental health service, like the professionals, but one stating that I was a PhD

student. I also tried to resemble the staff in clothing. I usually wore a clean, simple blouse, dark jeans and a suit-jacket. I was presented to the clinic by the professionals and I was introduced to the patients by them. Following the professionals and getting access to patients with their help was practical and seemed feasible. In any fieldwork, material and physical features of the world, as well as social and cultural aspects allow, encourage or block specific possibilities (Hastrup, 2010; Preissle & Grant, 2004). Because the institution was a clinic, the professionals were there constantly during working hours; however the patients came and went. If I were to follow someone then, it was necessarily the professionals. I will now look at how some of the professionals at the ward positioned me as a critical evaluator in a position of power above them. I suggest that this is indicative of a discursive norm among the professionals to be wary of criticism in the face of recent standardization processes.

Standardization and the researcher as a representative of the system

One of the professionals says “I have something for our group therapy, but I almost don’t dare to ask with Agnes here. I have a test in English, the newest test that is not translated to Danish yet. Isn’t it okay if I use the English one? Is that okay?” Everyone says that it is all right. She looks at me with an inquiring look and asks if I have any objections. I answer “No, not at all”.

P/O, p. 3

The fragment above is derived from the staff morning meeting during the first day of fieldwork at the clinic. The team member’s statement positions the researcher as someone who has the right to veto a decision approved by the team - and therefore in a superior position to them. Although I had tried to position myself as a naïve student among the professionals and said that I was there to learn from them, there were numerous examples from my field-notes of the professionals reacting to my presence with self-consciousness and something akin to submissiveness. During the fieldwork I interpreted these reactions as methodological problems. Perhaps I had not explained the aim of the study well enough or I had chosen the wrong approach. However, as the number of similar instances grew, I began to understand the professionals’ positioning of me as more than problems of access. The reactions of these team members seemed to extend the relationship to me as a person and indicated that many of the professionals generally expected to be surveyed

and criticized by outsiders. The health services in Denmark have been subject to an increased level of standardization and neo-liberal governing reforms (Holen, 2011; Magnussen, Saltman, & Vrangbæk, 2009) and the team was working hard on implementing these. Their progress was regularly surveyed, and praise or reprimands were given based on the team's efforts. Although some level of suspicion and wariness towards the ethnographic researcher is not uncommon in fieldwork in general (DeWalt & DeWalt, 2002; Harrington, 2003), it appeared that the specific positioning of the researcher as powerful and critical was connected to a discursive climate induced by the neo-liberal reforms. In the other setting of the fieldwork, the inpatient ward, a nurse even told me directly that some of her colleagues regarded me as a spy, and that in these times of standardization and quality development one can never be too sure. This indicates that the researcher positioning processes could be read as indicative of the discursive norms that operated in the context. The prevalence of neo-liberal discourses in mental health care thus seemed to have affected how the professionals could position themselves towards me. It was important for them not to be perceived as unprofessional, incompetent or to "lose face". In such a context, following the correct standard procedure became an important frame of reference for professionalism. The guidelines and benchmarking, intended to provide a higher standard of care, in practice therefore seemed to undermine the autonomy of professionals and made them cautious of making independent decisions (Holen, 2011; Speed, 2011).

Through following staff, my contact to the patients was mediated by the professionals and they influenced who, among the patients, I could interview and join in meetings. This provided few opportunities to negotiate or destabilize the position (Spanger, 2010). Although I emphasized confidentiality and my independence as a researcher, for some of the patients my position as researcher became blurred with the professionals. In the next section I look closely at the processes of researcher positioning during an interview with a patient, Frederik. The case is chosen as it is illustrative of the way many patients were inclined to position me as one of the professionals at the clinic. Furthermore, the case illustrates that a researcher position as "part of staff" sometimes had consequences for the way patients found it possible to interact with me. I suggest that the seemingly methodological problems that arose during the interview were indicative of a norm of the primacy of biomedical discourses within psychiatric care, excluding and rendering problematic alternative understandings of distress. However, I also argue the norm of bio-

medicine does not become entirely encompassing for how patients may define themselves in other contexts.

Biomedical discourses and the researcher as a member of staff

Frederik was a man in his twenties who had been sentenced to treatment and medication following a minor felony. His main psychiatric contact, the nurse Magda, told me that Frederik was a co-operative and low-maintenance patient with whom she had a good working-relationship. He had agreed to have me observe his meeting with Magda, and later interview him. As many professionals, Magda introduced me as a psychologist working on a research project. During the meeting Magda and Frederik mainly talked about medication. Frederik had stopped taking his medication for a few days and said that not taking it had made him feel better. Magda said that it was dangerous for him to experiment with it and it would be better to make an appointment with the doctor to make adjustments. She also said that she was obliged to mention that due to his sentence, it was compulsory for Frederik to take medication, and not doing so could lead to involuntary hospitalization. Although this element of coercion was present, the meeting was kept in a friendly, understanding and familiar tone. During the meeting Magda made some further references to me and my status as a psychologist.

Later the same day I interviewed Frederik. Trying to avoid a position as part of staff from the beginning, I had brought fruit and chocolate with me to the interview. As with all interviews I conducted, I started by asking about his life before entering psychiatry. This choice was motivated by a wish to not focus immediately on mental health issues (Deroche & Lahman, 2008) and to diverge as much as possible from a patient-professional meeting. However, Frederik answered that there was nothing “noteworthy” [bemærkelsesværdigt] about his life prior to hospitalization. Thereby he applied a criterion of topic-relevance from a biomedical discourse, which prioritizes issues directly related to illness and distress, while topics concerning other parts of life often are deemed less relevant (Boyle, 2011; Holen & Ahrenkiel, 2011). Despite my attempts, this situated the interview within the discursive genre (Wetherell, 2001: 18) of a patient-professional meeting, with me positioned as the professional.

Agnes: So what happened?

Frederik: Mm, But it was, that is (.) if you call it a psychosis or whatever you might call it, er, what happened anyway was, er, that my brain anyway played (.) a thought trick and my life, and made all sorts of things (.) yeah, it is also written in my file, er, what happened back then (.) er, I almost can't even explain it but, but I'm almost tired of talking about it.

Frederik, IV, p. 2

Within a bio-medical discourse mental distress and diagnoses are understood as underlying biological forces that act upon a person's personality and identity (Parker et al., 1995; Rapley, Moncrieff, & Dillon, 2011). By talking about the brain playing a trick, Frederik positions himself as a repository for cerebral forces and uses the psychiatric term "psychosis" to make sense of his experiences. He implies that his patient file may provide me with information, perhaps more factual and objective information than he could provide. I did look at medical records as part of the study and I had asked for his consent for getting access to the file. I made a point of explaining that my interest in the file was to see how professionals wrote about patients, not to get information on medical conditions. However, Frederik positions me as a person interested in expert statements on his psychiatric history - and himself as someone not well suited to provide these, or less suited than a patient record written by professionals. The statement that he is tired of talking about it further indicates that he does not wish to elaborate. However, the fragment also seems to indicate the existence of other possible discourses, specifically in the statement "psychosis or whatever you call it", even though these do not become immediately available. Later in the interview he described his first hospitalization:

A: What did you think about it at the time [during the first hospitalization]?

F: At the time I thought it was a terrible thing [*noget berrens noget*], it was phew! You shouldn't be here, like, I don't think it's good [rise in tempo of speech] because I am not sick or I am not, there is nothing wrong with me or what can you say (A: mm) So, so I fought like, a little against, like, that, the idea about it (A: mm) erm (5 s.) Erm, and I don't know if I still do, like a little (A: mm) but erm, I don't really know what I think about it (A: mm) with regards to just that. I haven't thought that much about it, heh [laughs], it's just something that has helped me, just through a period of time.

A: What has helped you?

F: Psychiatry

A: Mm (11 s.)

Frederik, IV, p. 4

Here, Frederik first talks about himself as someone who once did not think he belonged in a psychiatric ward - as someone who did not consider himself ill and was in opposition to the mental health services. Thereby he invokes potentially anti-psychiatric discourses (Speed, 2011). He also implies that this is a position he currently may identify with. Then he seems to wish to shake the position off by saying that he has not thought it through well. This may serve to make his previous account seem more throwaway (Margaret Wetherell, 2010) as if it was something he just thought of now. Jonathan Potter (1997) has coined the term *stake inoculation* for discursive strategies that people may use when they wish to say something potentially bold, but then do not wish to be perceived as having a stake or interest in a certain position. This may have the function of preventing the interlocutor from undermining their accounts. For Frederik, the “I don’t know if I still do”, “I really don’t know what to think about it”, “I haven’t thought that much about it” and the subsequent laugh, may function as just that; as a shield against a possible criticism or judgment of him, thereby positioning me as a person who could potentially undermine him. In response to many other questions, Frederik answered in a similar evasive or truncated manner and I grew increasingly frustrated that the interview was not proceeding well.

Alternative discourses and reworking the position of staff

Halfway into the interview, Frederik and I took a coffee-break and I turned off the recorder. I felt it necessary to explicitly readdress the question of my position. I told Frederik that it was true that I had studied psychology, but I was not a mental health professional. I did not have specific preconceptions about who and what may be considered ill. I was a researcher interested in his experiences. When we resumed the interview, this seemed to have caused a shift in Frederik’s way of addressing me and the stories he told. He asked if I was interested in hearing more about the voices he heard, despite previously stating that he was “almost tired of talking about it”. He explained in details

how he perceived the voices to be external to him, that they were of an abstract spiritual and sometimes positive nature, and not pathological. At the same time, he said he believed he could not share these thoughts with the mental health staff:

F: I just think that feeling comfortable and feeling, feeling comfortable with saying what you, kind of what your inner torments are [is not possible] because erm, I feel like they [mental health professionals] understand it one way, or the way that is uh, the prevailing understanding (A: mm) and I understand it in a totally different way and I don't think I can explain myself out of it like that: "I see it this way instead". So, so I keep it to myself instead and I try to avoid talking to them about it (A: mm) Yes, I have always seen it as something that just needs to be gotten over with.

Frederik, IV, p. 25

In this fragment towards the end of the interview, Frederik positions himself as someone who has learned to manage the contact with mental health professionals, specifically by avoiding disclosures of too much personal information. A similar dynamic appeared to have taken place between interviewer and interviewee throughout the first part of the interview, when he had positioned me as a mental health professional. Researchers have noted the resemblance between the qualitative research interview and clinical or psychotherapeutic encounters (Fog, 2004; Kvale & Brinkmann, 2009). They note that there is a risk that the intimacy of an interview situation may cause participants to reveal personal information they will later regret. This is an important point that should always be taken into consideration when doing interview research, perhaps especially within clinical settings. For Frederik, however, the proximity of the research interview to a clinical session and the positioning of me as a mental health professional seemed to have had the opposite effect. Instead of excessively revealing personal information, he wished to reveal as little personal information as possible, when that information potentially diverged from a mainstream psychiatric discourse. It was only when the interviewer could be positioned outside of the category of "mental health professional" that he could draw on alternative discourses to the dominant psychiatric one.

At first glance, Frederik's uneasiness and evasive answers in the first part of the interview might have been thought of as mere technical problems be-

tween the interviewer and the informant. However, a closer look suggests that the methodical problems become meaningful in light of discursive norms and subject positions within the institution. Barrett (1996) and Parker et al. (1995) have noted that through repeated interactions with professionals, psychiatric patients learn to define their experiences in relation to professional categories and norms - and thus learn to become competent patients. On the other hand, patients risk rejection or being discredited if they position themselves within less established forms of knowledge (Parker et al., 1995). Throughout the fieldwork, I learned that there was a potential risk involved for patients who admitted to unconventional understandings of their distress. Patients who said they were not ill or whose explanations for their distress diverged a lot from psychiatric discourses were frequently labeled as “lacking in insight” into their illnesses (Dillon, 2011). Within the mental health services, patients who were thought of as “lacking in insight” were often considered uncooperative and very ill. Consequently, it was not an attractive position to be placed in. Seen in this light, Frederik’s strategies for mitigating potentially problematic utterances in the interview can be seen as a way of shielding against being positioned as “lacking in insight” by the interviewer - whom he perceived to be part of the professional group. What I experienced during the interview as technical problems thus rather seemed to be an indication of norms and expectations regarding how patients could talk and position themselves within the mental health services in order to be perceived as easy to deal with and co-operative.

What the case of Frederik further illustrates is not that alternative discourses of distress become absent in a person’s self-constructions when becoming a psychiatric patient, but rather that there can be difficulties and risks involved in expressing these in interactions with professionals. At the same time, the interview illustrates that there is a potential for resisting psychiatric discourses in accordance with the demands of the discursive context (Parker et al., 1995). As much as reductionist discourses of illness and disease may become the main frame of reference in meetings with professionals, they do not necessarily become generalized to how patients define and position themselves in other contexts. This showed me the importance of studying not only how patients are talked to and about in the mental health services, but also how they themselves talk about the mental health services - and the self-constructions that become available to them when doing so. I thus became aware of the importance of conducting interviews as part of the fieldwork. By basing most

of the material on observations and by following professionals, I risked ignoring discourses that could sometimes not be expressed in patient-professional interactions.

Second field: Negotiating “least staff” researcher positions at a secured psychiatric ward

The interview with Frederik made it clear that if I wished to gain access to discourses that were sometimes silenced in interactions with professionals, it was important that the patients did not position me as part of the professional group. In the second field, the secured inpatient ward, I therefore sought to negotiate an approach that would make it possible for me to be positioned as “least staff”²¹: to diverge from the staff category as much as possible and not be seen as affiliated with them. On the entrance meetings with the professionals of the ward during which I told them about the study, I therefore explained that I wished to get to know the patients first and spend time with them, as my research design made it important that the patients did not think of me as part of staff. As I also wished to produce data on how the professionals talked about the patients in their absence, I added that towards the end of the fieldwork I would like to deviate from this rule – and join the professionals on staff meetings and interview them.

In order to avoid being positioned as staff, when entering the ward I had to create a visible connection with the patients. Having made up my mind to position myself as recognizable to patients, I was aware to signal with body signs (Søndergaard, 2006), my clothes and body language, a stronger belonging to them than to the professionals (S Estroff, 1985). I learned to wear worn jeans and loose t-shirts, no jewelry, and sport shoes, thereby resembling the way some of the patients dressed. I refrained from wearing an identity tag or a security alarm like the staff. In the beginning of the field work I avoided

²¹ The term “least staff” is inspired by Nancy Mandell (1988), who, while doing research on children’s social worlds in nurseries, developed an approach she calls the “least adult” role. Mandell’s “least adult” role is practiced by her participating as one of the children and subordinating to the authority of the teachers, although with a constant awareness that she cannot actually become one of the children. More recently in a Danish context, Hanne Warming (2005) has redeveloped the concept within a poststructural framework.

going near the staff room. Only professionals were allowed into the staff room, and patients would knock on the door and stand outside while talking to a professional. I also joined the patients' activities rather than the professionals: used the patient lavatory, rather than the one reserved for staff, drank coffee when it was served to patients, and, lastly, went to the smoking room with the patients who smoked. Smoking turned out to be an important activity for many patients and some spent a great proportion of their time in the smoking room. The strategy opened a forum for just sitting with the smoking patients on the pretense that I "just needed a smoke". At other times I attempted to "just hang around", sitting relaxed and silent, folded up on the couch (S Estroff, 1985) in the common room. However, for my identity claims as "least staff" to work, they had to be accepted by the research participants (Harrington, 2003). The next section looks at how the patients at the ward reacted to and positioned the researcher in light of my attempts to position myself as "least staff". I discuss that my attempted positioning as "least staff" triggered more implicit or explicit resistance from the patients than what I had experienced at the clinic. The resistance to me, I suggest, was associated with a resistance to objectification; a resistance that at the same time could be difficult for patients to express when interacting with professionals.

Decoding the researcher's interests and resistance to objectification

Unlike the patients at the clinic, with whom I mostly talked during formal interviews or observed during meetings with professionals; with my "least staff" identity-claim I was able to develop more informal and long-lasting relationships with many patients at the ward. However, just as with the interview with Frederik at the clinic, there was a tendency that some patients at the ward initially positioned me as interested in their "illness".

I am sitting with some of the female patients in the activity room. One of them has brought a kit for painting and decorating finger nails. They have asked if I want to join them and also have my nails painted and I have happily agreed. I bring some sweets that I have kept in my backpack and we share them while we are getting our nails painted by Julia, who has been a patient at the ward for some time. Julia says: "Ha, you're giving us sweets so that we will tell you about our mental problems". I answer that I'm actually more interested in how they experience the mental health services than in their problems, "but", I jokingly add, "it is correct that I am bribing you". We laugh.

Julia's attempt to decode the researcher's aims and interests reveals something about what patients at a psychiatric ward might expect others to find interesting about them (Jensen, 2009). She is used to talking about her personal difficulties with professionals and knows that being a psychiatric patient, having "mental problems" and a psychiatric diagnosis, positions her as different from the norm; a norm of which the researcher in this case is a representative. At the same time she makes fun of the researcher's intentions and practices. The researcher is positioned as someone who wishes to objectify the patients by studying their "mental problems" - but at the same time doesn't have the authority of the professionals to do so - and thus is forced to bribe her way to gaining access. Julia's reaction and articulation of what she perceives to be the researcher's aims may be seen as a type of resistance against being objectified by the researcher's gaze (Foucault, 2003b; Jensen, 2009). She practices resistance by the use of irony - and throughout the fieldwork there were numerous examples of her reacting to my presence this way. In the former setting, the outpatient clinic, I wrote fieldnotes during almost all my observations. The professionals had sometimes commented on this, but the patients never mentioned my writing practices. At the ward, however, the informality of my interactions with the patients often prevented me from taking notes (Emerson et al., 1995). In the few situations in which I tried jotting some words down in the presence of Julia, she commented on it and mocked me: "Oh, there the journalist appeared in her!" or "Are you getting something to write about? You love this, don't you?". Her reactions may be read as confronting the researcher with the fact that the researcher, because of her academic position, has the possibility of producing authoritative accounts on the patients (Jensen, 2009). Thus, they are an ironic comment on the power that lies in the objectifying practices of the researcher - and at the same time an indication that she opposes to the objectification. Other patients sometimes showed resistance to the researcher's objectifying practices by avoiding talking about the things the researcher was interested in, or what they thought the researcher was interested in. In my fieldnotes I wrote about another patient, Mark:

Mark walked by my side all day today and followed me around, but he did not want to talk about the mental health services when I asked about his experiences of them. Whenever I tried asking him he changed the subject and talked about different songs he had listened to, films he had seen and books

that interested him. He asked me many questions about these and whether I had heard of them. I finally asked him directly if he would like to participate in an interview, but he said no. I asked him why and he said he doesn't like to blabber and go on and on. I asked what he meant and he said "well, about things like my illness and stuff". I said that I actually rather wanted to ask him about how he experiences the mental health services. He answered "it's personal".

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My questions about Mark's experiences of psychiatric care places him in the position of "psychiatric patient". Thereby I implicitly point out the differences between us, positioning myself as the norm and him as deviant from it. Mark's avoidance of my questions and resistance to participating in an interview can be read as him resisting precisely the categorization as "psychiatric patient". Like Julia he positions the researcher as primarily interested in a biomedical condition – "my illness" – and distances himself from that position. Experiencing or thinking that others may find you interesting only because of an illness that makes you deviant and perhaps inferior to the norm, calls for a rejection of that position. Mark's response is to disidentify (Jensen, 2009; Skeggs, 1997) from the position of "mentally ill" by rejecting any topics introduced by the researcher that hint at his status as psychiatric patient. Thereby he markedly distances himself from the position he perceives the researcher to place him in - and normalizes the situation by drawing on a repertoire of topics from everyday conversations: books, films and music.

Mark and Julia's mockery and resistance to me can be read as subtle antagonisms within the institution and in society moving into the researcher's relations with the participants. They both expected me to be interested primarily in their illness, but seemed to resist this classification of them. It is interesting that the patients in the former field, the outpatient clinic, had not reacted in the same ironic and resisting way when I was introduced to them by professionals. One interpretation of this could be that when the patients had me positioned as part of the professional group they expected me to objectify them and, as in the case of Frederik, objectified themselves to me - by constructing themselves as passive repositories of pathology (Speed, 2011). This can be tied to Foucauldian notions of how psychiatric patients learn to make themselves objects for biomedical interventions and in the light of these learn to reflect on themselves as objects (Foucault, 2003b, 2005). Such a process of

objectification may become invisible for patients, as it just becomes a naturalized form of interaction within the mental health services (Barrett, 1996). However, engaging with the researcher, who shifted positions between regular talk and objectifying note-taking, might have made the objectifying practices more visible. The patients' reactions to me can thus be read as an index to the varying and complex forms of resistance that become available to patients in different discursive contexts. In the next section, I will look closely at one specific context of my interactions with the patients, the smoking room. I argue that the patients' reactions to my presence there and the positioning of me as a "fellow smoker" point to the importance of physical space in creating pockets of resistance for the patients.

The symbolic meaning of the smoking room and the researcher as a fellow smoker

The patients Dina, Julia and Laura go out to smoke in the smoking room. I take out my own pack of cigarettes and go out with them. Dina makes a surprised, slightly disapproving face and asks: "What are you doing?!". Laura answers: "she wants to smoke". I ask if that is alright. Julia says "of course it is". "Oh", Dina says, "I thought you were from the staff, they're not allowed to smoke with us". I say, no I'm not, and I introduce myself. She answers: "Oh, so you're the one doing that study". I say yes. They keep talking. Dina turns to the group and says that she tried to burn her jeans yesterday. Then she describes a suicide attempt involving 300 painkillers. She explains that after she had swallowed them she called her boyfriend who called an ambulance for her. She says that she has done the same thing four times before.

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Joining the patients in the designated smoking area – the smoking room – turned out to be the most important way for me to attempt being positioned as least staff. As I learned from Dina's reaction to my presence, smoking in the smoking room was an activity reserved for the patients alone; the professionals were not allowed to smoke with them. When the specific event above took place I had already joined Laura and Julia in the smoking room on numerous occasions. Dina had largely stayed in her own room and hence I had not had the chance to speak to her before. Dina's negative reactions to my presence when she thought I was part of staff, and her subsequent willingness

to speak openly about her suicide attempt, when the others assured it was legitimate for me to be there, can be read as indicative of some of the norms and practices guarding the patients' everyday interactions at the ward. As the professionals were afraid that some patients would disclose personal information they may later regret, the ward had a rule that patients were not allowed to talk to each other about emotional distress. I observed a few times how the rule was implemented: if a patient attempted to share experiences of distress with other patients in front of professionals, that person was escorted away from the other patients and invited instead to have a talk with one of the professionals. Most patients thus learned to balance what they could say to each other in the ordinary spaces of the ward - and the topics discussed were typically on mundane, everyday themes. However, Dina's openness about her suicide attempt and positioning of me as a fellow smoker in the context of the smoking room indicates the "otherness" of this particular space (McGrath, 2012). In it, as opposed to other contexts of the ward, the patients could talk freely about their distress and negotiate the topics of discussion among themselves.

Perhaps because of its status as a special or "other" place, the smoking room was subject to discussions and conflicts between professionals and patients. Explaining to me that they wished to reduce the time spent in the smoking room and prevent the formation of cliques, the professionals introduced a rule that smokers were not allowed to sit on the floor while smoking, but had to stand up. This rule was subject to discussions both within the patient group and during common meetings with professionals. Not all patients showed interest in the rule, but most smokers disagreed with it. The conflict led to tensions regarding me and who I would side with. As I also wished to be positioned as trustworthy by the professionals, I adhered to the ban on sitting down, but kept going to the smoking room with the smoking patients.

I go out to smoke with Hanna, David and Carl. The nurses Niklas and Ida are sitting in the common room just by the smoking room watching television. Hanna sits down by the wall in the smoking room, so the nurses can't see her. David, who is standing in front of the transparent glass door, visible to the professionals, starts to sit down too, but rises quickly again. We talk about Hanna's plans to move to a group home [...] Then Hanna turns to me and says jokingly: "You know that you are violating the rules. You are talking out here". I decide to go along, I cover my mouth and I say "sorry" with an ironic tone.

Hanna introduces a discourse of resistance against the rules evoked by the professionals. She exaggerates the ban on sitting down and calls it a ban on talking, thereby positioning the professionals as unnecessarily authoritarian. At the same time, she positions me as someone who, like her, is violating the rules and is oppositional to them. Thereby she constructs sameness and commonality (Khawaja & Mørck, 2009), implying that we have the same rules to adjust to - as we are engaging in the same activity. Although I had not earlier addressed the conflict, in an effort to position myself as trustworthy, I accepted the position, implicitly marking my sympathy to her viewpoints and distancing myself from the rules in a slightly mocking fashion. This action was a way of “doing trust” (Jefferson & Huniche, 2009), creating a connection with Hanna by positioning myself off the staff category. I thus co-constructed the discourse of resistance towards the professionals’ authority that Hanna initiated.

The positioning of me as a fellow smoker in the context of the smoking room, I suggest, points to the “otherness” of this specific place, in that it could provide a pocket of explicit resistance for the patients at the ward. At the ward, all other places were potentially places of “treatment” where the patients were “being treated” and the professionals were treating them (McGrath, 2012). Patients were openly subject to the psychiatric gaze – expressed in fine mechanisms of surveillance and control (Foucault, 1991c, 2003b). The interactions in the smoking room, however, provided occasions for other types of positioning than “patient being treated” and in it, the patients could negotiate topics of conversation without the influence of professionals. The smoking room was thus produced as a “private space” (McGrath, 2012) that could temporarily destabilize a patient position. Had I not been invited into a position as a fellow smoker, this function of the smoking room would have escaped my attention. The positioning of the researcher as a fellow smoker thus made visible the norms and practices of patients in the particular context of the smoking room. The “otherness” of the smoking room in term indicated some aspect of the discursive norms shaping how to be a patient in the other spaces at the ward; often involving negotiating a patient position in an institutionally sanctioned manner.

As much as some patients came to position me as a “fellow smoker” or outside of the staff category in many instances, the professionals of the ward appeared to position me as belonging to the category “most staff” or “least patient”. The next section analyzes how some professionals at the ward expected me to participate with the rights and duties inherent in a staff position. I suggest that this is indicative of a discursive norm within the mental health services that is based on a polarized dichotomy of “normality” and “pathology”.

Discourses of pathology and normality - the researcher as “least patient”

Because I wished to establish a “least staff” position at the ward, in the early days of fieldwork I had rare contact with most professionals. However a few professionals did approach me, mostly two nurses and a nursing student. At one point during the first weeks of the fieldwork, the nurse Andrea approached me when I was alone in the common room and addressed a problem they were experiencing. It was prohibited to have romantic relationships at the ward, but the patients Clara and Frank had formed a couple:

Andrea sighs and says that there is a bad atmosphere at the ward because they have a lot of personality disordered patients at the moment. She says that she has noticed that I walk around without a security alarm [...] She goes to the staff room and brings an alarm that she gives me. She says: “Hey by the way, if you see Clara and Frank kissing, you can correct them” I answer “ehhmmmm... I don’t think I can”. She says: “Then go get Stine [another nurse] to do it, she will be at work while I am away now, so she can correct them. They are not allowed to kiss; it creates an uneasy atmosphere among the other patients.” She shows me how the alarm works and that she wears hers under her shirt. I go to the toilet and I try out different solutions to hide the alarm. I think about how wearing it really associates me with the staff.

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Here, despite the explicit efforts I had made to distance myself from the category “staff”, Andrea expects me to participate with the same rights and duties as the professionals. She constructs the patients as easy to distress and positions me and herself outside the category patient. As I also wished to be positioned as trustworthy by her and the other professionals, I accepted the alarm

and I did not openly oppose the idea of fetching a nurse if I saw the patients kiss, although I did not make use of it later on, as it would have compromised my position of trustworthy among patients. The position that I was invited into and my response to it were further made more complex by some incidents that had occurred recently: one patient had acted threateningly towards me, which had made me more willing to accept the alarm. This shows that Andrea's concern and wish to protect me, although she probably was unaware of the incidents, was not meaningless or uncalled for. In the light of this, I also began to experience some patients as unpredictable and easy to distress, which at times complicated my position and relationship to them. This indicates how the positions of researcher, professional, and patient intersected and produced relationships that could not be controlled or predicted prior to the fieldwork. The researcher-participant positioning had to be constantly negotiated and re-negotiated, if I wished to be positioned as trustworthy by all participants.

The position that the professionals invited me into was a dilemmatic one. While an increasing amount of patients came to position me frequently as "least staff", the professionals usually seemed to position me as "least patient" when I interacted with them. The issues of belonging to one group or the other became increasingly challenging when I started having more regular contact with the professionals. I felt as if I was being disloyal to one of the groups when I was with the other. The challenges were amplified when I was with both professionals and patients in the same room:

I'm sitting in the common room with Julia and with the nursing intern Jasmin. The patient Emma comes in and sits down next to me. Frank comes in and sits down too. Emma asks Frank: "What actually happened between you and Clara, are you a couple now, or what?" Frank says that they are, that he only wants Clara and that's the way it is. Emma asks if he is in love with her. Frank says that he is very much in love, and then he leaves. The nursing intern Jasmin looks at me and says "we really have to report this to the other staff". I mumble indistinctly that I won't. The others go out to smoke. I ask Jasmin if she thinks it's okay if I join them. She says she thinks it's alright. According to house rules, she says, one is not allowed to join the patients, but maybe that has nothing to do with me. I go to the smoking room. The patients in there are talking about Frank and Clara. They say they think it's disgusting. Julia says that they're not allowed to kiss according to house rules. She looks at me and says: "yeah, Jasmin said that she would tell the staff". I

say “I won’t tell, it’s important that you know that I won’t tell the things you say to me”.

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Here, the nursing student Jasmin, like Andrea, assigns to me the same duties as the professionals: reporting a violation of house rules. And just as with Andrea, I found it difficult to respond properly. Not opposing Jasmin’s suggestion that we should report the violation to the other members of staff would have positioned me as untrustworthy in the eyes of the witnessing patients. However opposing Jasmin’s suggestion may have positioned me as disloyal from her perspective. My response was to very hesitantly disagree with Jasmin at first and later to attempt to disidentify from the staff category explicitly among the patients.

Again, here I suggest that the dilemmas encountered with Jasmin and Andrea can be read as indicative of norms in the mental health services. The often mutually exclusive expectations about who I was and what my duties were indicate that the staff and patient categories were produced as polarized binary pairs. The “we” that the members of staff constructed with the researcher was not based on a commonality of people participating in similar activities or presenting similar body signs, as I had strived to act like and to look different from the professionals. The common link between us seemed to be based on something else; a discourse of pathology and normality, offering the category “mentally sane” as a decisive marker of commonality between the researcher and the nurses. According to the discourse, since the researcher is not a psychiatric patient, and therefore in the “normality” end of the dichotomy, she may take on the duties of the professionals and be in a position of authority above the patients.

Parker et al. (1995) note that pathology versus normality, reason versus unreason, professional views versus patient views are culturally produced as binary opposites. These make certain versions of reality thinkable and practicable, while excluding others. From this perspective, the categories “staff” and “patient” just as “pathology” and “normality” may be seen as regulating and dividing practices that differentiate between people. Such dividing practices affect the categories of behavior that are considered pathological, removing them from the realm of normalcy, and thus from being understood within their social context. Rosenhan (1973) has demonstrated that whatever psychi-

atric patients do at a ward, their behavior can be interpreted as pathological simply because they have been labeled psychiatric patients. Similarly, whatever I seemed to do at the ward, because I was not a psychiatric patient, I was constructed by the professionals as non-patient and therefore closer to the members of staff. This is indicative of a discursive norm that produces the categories “patient” and “staff” as binary, with little leverage for negotiating spaces in between. Thus, just as the binary pairs were active in positioning the researcher constantly during fieldwork, with few possibilities of negotiating positions “in between”, so might the binaries have been difficult to penetrate for both patients and professionals.

Concluding reflections across fields

This paper illustrates the importance of reading the processes of researcher-participant positioning as sources of data. This perspective invites us to see methodological problems as based on discursive norms that operate within the field. In the study, the researcher positions that were made available became an important source of knowledge about the discursive norms and social categories that operated within the mental health services.

Firstly, throughout the fieldwork, the categories “patient” and “professional”, and the binary pairs “pathology” and “normality” worked as a structuring norm in all my interactions with participants. It seemed as if in order to get closer to the patients and understand how they made sense of their experiences within the mental health services, I often had to be positioned as “least staff”; while for the professionals to relate to me I had to be positioned as “least patient”. Just as discourses of sanity and insanity provided categories that structured the researcher-participant interactions, they appeared to provide boundaries that shaped how the patients and professionals could be defined. The problems associated with negotiating a position from which I could reach both groups therefore seemed to be indicative of the norms and dividing practices that separate patients and professionals.

Secondly, the patients’ expectations that I wanted them to talk about “illness” indicate the power of biomedical discourses in structuring how the patients define themselves in relation to the mental health services. At the same time, the patients who participated in the study were far from passive in their inter-

actions with me and in their self-positioning. They resisted the objectifying practices of the researcher as well as those of the mental health services in several ways. This capacity to resist psychiatric discourses is often downplayed in the literature on psychiatric institutions and patient identities. However, during the study it became evident that discourses of resistance became more available to the patients when they could position me as “non or least staff” or when I could join them in settings that were seen as “other” than psychiatric. This indicated that the patients modulated what could be said in accordance with the demands of the discursive context.

Thirdly, the reactions of the professionals to my presence were to position me as “least patient” and sometimes as a powerful evaluator who had the right to criticize them. These, I have argued, can be read as indicative of a discourse that polarizes pathology and normality and of a norm that sets adhering to standards as an ideal for professionalism. This indicates that, just like the patients, the professionals were not entirely free, but relied on discursive norms that formed what they could do and how they could understand themselves.

The paper thus points to the importance of understanding researcher-participant relationships as processes of positioning among people who are already positioned in different ways. The centrality of a discourse of pathology in the researcher-participant relationships indicates the power of this discourse in shaping interactions in the institution. However it also indicates that the institution is embedded in a wider cultural reality that puts in place a firm distinction between normality and deviance (Jensen, 2009). In conclusion, then, the paper shows that researcher-participant positioning is shaped by pre-existing discursive norms, but also that psychiatric patients, who are often thought of as marginalized and passive, are active and reflexive when they position themselves in relation to the mental health services.

This raises some questions regarding service user involvement and patient-centered care. Service user involvement is often defined as treatment: “taking as a starting point the patient’s experiences and wishes” (Psykiatrien Region Sjælland, 2010:3, my translation). Such a statement assumes an uncomplicated and static relationship between patients, their wishes and the role of the mental health services. However, as we have seen, these are not free from issues of positioning, constraints of the discursive context and dominant discourses.

If patients learn that they are valued and regarded as competent insofar as they demonstrate a willingness to accept and actively adapt the understandings of the mental health services, the question of how to involve their perspectives in the treatment is not a straightforward matter. Furthermore, service-user involvement is often constructed as a concept that can be implemented smoothly if the individual professionals are more attentive to the wishes of patients. However, the analysis indicates that the actions of professionals are never entirely free, but rely on interplays of wider discourses that form what they can do. If professionals undermine their own reflexive choices in the face of standards and benchmarking - and if patients learn not to ask questions or challenge prevailing discourses and norms - the question of involving patients' perspectives is a complex matter that does not only depend on the willingness or the personal characteristics of professionals and patients.

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Article 2: “Hell no, they’ll think you’re mad as a hatter”: Illness discourses and their implications for patients in mental health practice.

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Abstract

Illness definitions and classifications of patients' conditions play a central role in the way mental health professionals interact with patients and the way patients may make sense of their difficulties. This paper examines how ideas about mental illness are negotiated in mental health practice and the implications of these negotiations for psychiatric patients. Based on a Foucauldian analysis of ethnographic data from two mental health institutions in Denmark – an outpatient clinic and an inpatient ward – the paper defines three discourses that were found to play a part in definitions of the patients' difficulties. We name these the *instability discourse*, the *discourse of “really ill”* and the *lack of insight discourse*. The paper indicates that patients are required to develop a finely-tuned and precise sense for the discourses and to make strategic considerations as to how to appear in front of professionals if they wish to have a say in the treatment. Thus we argue that illness definitions in mental health practice are not only materialized as static biomedical understandings, but are complex and diverse. The implications of the discourses for the policy and practice of service user involvement are discussed.

Keywords: Mental illness; Psychiatric practice; Discourse; Discursive positioning; Patient experience

Introduction

A central tenet of mental health policy and practice in recent decades has been to work towards a more active involvement of patients in the treatment. However there is an increasing amount of research which calls into question the extent to which patients and their perspectives are actually being involved in the delivery and planning of mental health services (Bowl, 1996; Pilgrim & Waldron, 1998; Roberts, 2010). While there may be a number of obstacles to involving patients in the treatment, it has been suggested that psychiatric definitions of mental illnesses, with their restrictive deficit-oriented categories of mental distress, may serve as a barrier to involving patients' perspectives (Roberts, 2010). However, how mental illness is negotiated in psychiatric set-

tings and their implications for the patients and for involving them in the treatment has not yet been extensively researched.

This paper examines how definitions of mental illness are negotiated in meetings between patients and professionals in psychiatric settings and their implications for patients and for the practice of user involvement. We analyze data from an ethnographic study of two mental health institutions in Denmark – one outpatient clinic and a secured inpatient ward. We identify three local discourses derived from how the professionals and patients in the institutions talked about mental illness, which we name: the instability discourse, the discourse of “really ill” and the lack-of-insight discourse. We examine the effects of the discourses on the patients’ possibilities to understand themselves and to become understandable and receive help from professionals. Towards the end of the paper we relate our discussion to the policy and practice of user involvement.

Narratives and discourses of mental distress

It has been well documented that people who use mental health services use a range of explanatory strategies to make sense of their mental distress, often diverging from formal diagnostic definitions. Studies have demonstrated that when defining their distress, psychiatric patients tend to either draw on a biomedical discourse, some version of a psycho-social discourse, or take a stance which negates a bio-medical definition of distress by drawing on alternative spiritual or anti-psychiatric discourses (Cardano, 2010; SE Estroff, 1991; J. Larsen, 2004; Speed, 2006). For example, in Italy, Cardano (2010) interviewed psychiatric patients and members of the Hearing Voices Network, a critical non-psychiatric movement for people who hear voices, to study their narratives of distress. He identified three “ideal types” of illness-narratives: bio-medical, psycho-social and spiritual-religious narratives. Bio-medical narratives constructed the “illness” as due to brain or body dysfunction and called for pharmacological solutions. Psycho-social narratives constructed the distress as resulting from social and psychological factors such as loneliness and dependence on others. Spiritual-magical narratives constructed the distress as either due to the malice of the devil, or reflecting voices from ancestors. Cardano found that among the participants who were psychiatric patients, their distress was generally qualified as undesirable *stigma*, while the

one participant who had not been receiving psychiatric treatment was able to qualify her diversity as *charisma*, as a gift, making sense of her voices through her work as a medium. Similarly, in a study on narratives of patients with psychotic experiences in Denmark, Larsen (2004) distinguished between patients who dogmatically embraced the narratives of the psychiatric system and understood their distress in terms of cognitive or bio-medical deficits, and those who were reflexive and creative *bricoleurs* of different systems of meaning, incorporating spiritual and non-psychiatric explanations.

What these studies share is a focus on the individual patient, investigating personal sense-making strategies of distress in terms of their proximity to standard psychiatric models - while often portraying mental health services as institutions which solely or mostly make use of bio-medical, psychiatric discourses. Analyses of illness discourses and practices in institutional settings have offered an alternative and valuable perspective on the discourses in psychiatric institutions, focusing on how these are complex and multiple and do not just consist of straightforward biomedical definitions. Ethnographies of mental health services have e.g. shown how professionals tend to make use of pragmatic choices, rather than biomedical reasoning, in diagnostic practices (Rhodes, 1995); how professionals, rather than relying on one model, make use of a patchwork of social, clinical and even anti-psychiatric theories in their clinical work with patients (Rhodes, 1995); and how clinical practice is permeated by a constant tension between practices which construct the patient as a passive object versus practices which construct the patient as a volitional and moral subject (Barrett, 1996). A central tenet of these approaches has been to focus on the relation between psychiatric knowledge, professional practices and patients' experiences. However few have explored particular local discourses drawn on and emerging in everyday psychiatric practice - or their implications for patients and for involving them in the treatment.

This article is dedicated to analyzing discourses on mental illness in everyday practices of mental health services - how these have implications for psychiatric patients and for the practice of user involvement. During the study it became evident that a range of local discourses on illness which were connected to, but not synonymous with broader psychiatric discourses, were present in the settings we studied. We therefore suggest that the ways of talking about mental illness in mental health care ought to be understood as complex and diverse - and not just as literal translations of diagnostic classifications.

The discourse analysis applied in this article draws from poststructural perspectives which challenge modernist assumptions about truth, identity, rationality and the individual. Discourses are understood here in a Foucauldian sense, as groups of signs and practices that systematically form the objects and subjects of which they speak (Foucault, 2004:54). From this perspective discourses provide particular ways of ordering and making sense of the world, including ourselves. They make available certain discursive positions which we can occupy, with implications for how others will perceive us and how we will experience ourselves. The positions provide rights and responsibilities to those who occupy them and shape what can be said and done from within a certain position (Davies & Harré, 1990). Some positions are more stable, but in theory all positions can be contested and renegotiated by speakers, who are active users of discursive resources.

Based on interviews and participant observations, we develop a framework consisting of three discourses on mental illness that were drawn on in the practices of the studied psychiatric settings. The three discourses seemed to cut across the spectrum of psychiatric diagnoses, but could manifest themselves in slightly differentiated ways, depending on whether the specific conversation was about schizophrenia, borderline, bipolar disorder, etc.

Research design

The material on which this paper is based on is drawn from a three-month (240 h) ethnographic study conducted by the first author (AR) at two general psychiatric institutions for adults in Denmark in 2011. One of the institutions was an outpatient clinic and the other an inpatient ward; both were situated in two medium-sized towns in Denmark. The clinic had a staff group of 13 multi-disciplinary professionals who provided services to 280 patients who came in for scheduled appointments. The ward was a secured acute unit with a staff group of approximately 27 professionals and a number of substitutes who provided inpatient services to 14 inpatients.

The fieldwork involved participant observation of everyday life at the institutions: meetings between professionals and patients, treatment groups, staff meetings and periods of idle time. Semi-structured interviews with 13 patients and 11 professionals lasting between 0.5-1.5 hours were conducted. In select-

ing the informants for interviews, a principle of maximum variation (Polkinghorne, 2005) was applied; professionals and patients positioned as diversely as possible in the organization were invited to participate in interviews. A postmodern theory of knowledge informed all the stages of the research process, including the data collection. The researcher was not cast as a neutral observer, but as an active participant whose positionality and subjectivity were seen as crucial for the production and analysis of data (Haraway, 1988; Ringer, 2013). Notes were written during or immediately after each participant observation and were elaborated into fieldnotes later the same day. Extracts from participant observation data are marked in the paper as “P/O”. All interviews were audio-recorded and transcribed verbatim; data extracts from the interviews are marked in the text as “name, IV”. All names of participants are pseudonyms and information which may compromise anonymity has been changed.

The analysis was informed by a version of discourse analysis inspired by the work of Foucault (Willig, 2008). This type of analysis involves asking questions about constructions, discourses, action orientation, discursive positions and their implications for subjectivity and practice. It is based on the notion that discourses construct the objects and subjects of which they speak. Discourses thus enable and restrain what can potentially be said, done, thought, experienced and felt - and thus have implications for subjectivity and practice (Willig, 2008). In the preliminary coding of the data, illness definitions turned out to be an important and widespread theme. All instances of talk about illness or distress were therefore highlighted and grouped into subthemes in order to identify specific discourses that the participants drew on. All the cases presented here were cross-checked between the two authors and were finally selected as some of the most illustrative examples of each discourse.

Approval for conducting the study was granted by the Danish Data Protection Agency and the hospitals, in accordance with the Danish standards for health research. Quotations and fieldnotes presented in this article have been translated from Danish to the nearest equivalent English.

The instability discourse

In both settings constructions of patients' identities tended to oscillate between constructions as moral subjects who could be responsible for their actions and passive objects without agency or volition. When the patient was constructed as a moral subject, she was seen as responsible and volitional, when she was constructed as an object, she was seen as influenced by forces beyond voluntary control. The instability discourse often emerged as a version of the latter, especially in situations when patients' behaviors did not immediately make sense or were difficult to understand. In these situations, the patients' distress was often attributed responsibility, and the illness was endowed with unpredictable and unstable powers:

Six professionals are having a supervision session with an external supervisor. One of the nurses has just brought up a case: a patient who all of a sudden said that he did not wish to see her again. The nurse says the rejection caught her by surprise since she thought that she had developed a good relationship with the patient. The supervisor turns to the whole group and says, "People with mental illness oscillate a lot. We are very stable, but they have this instability. We are on automatic pilot, but when we meet them we need to think about where we place the explanation. In normal relationships we usually think 'oops, it's my fault', but when we get knowledge about the patient, when we know what happens to schizophrenics, what should we be aware of? [...] Because they are so unstable and you are so stable."

P/O, p. 158-159

In the extract above, the supervisor had initially asked some questions regarding what happened between the nurse and the patient, but finally resorted to the patient's illness or inherent "instability" in order to make sense of the rejection. In this way, the rejection was constructed as reflecting an inner unstable state within the patient, rather than being explicable through references to the context or to the relationship between the nurse and the patient. The statement invites the professionals into a position as "stable" and "normal", whereas the patient is positioned as "unstable" and "schizophrenic" – two positions that seem irreconcilable. Parker et al. (1995) have noted that when a person's actions are considered pathological, they become removed from the realm of normalcy, and thus from being understood within their social context. In this way, the conclusion of the patient's actions as stemming from an illness seemed to rule out other explanations and discourage further exploration of the content of the relationship. The instability discourse thus served

to portray the illness as a decontextualized, unstable and unpredictable entity being out of the patient's and the nurse's control.

Foucault (1985) writes that discourses produce and uphold "moral codes" that construct what is wrong and right, true or false. One such moral code within the professional discourse of mental health may be that professionals are expected to develop trusting, empathetic and stable relationships with their patients. If a patient wishes to break off the relationship this can therefore be construed as a failure on the part of the clinician, potentially posing a threat to professional identity and institutional expectations. In this case, the instability discourse may function as a welcome explanatory tool for avoiding blame and responsibility. It invited the supervisor and the nurse to locate the responsibility for the failed relationship in the patient and his illness, thus evading moral responsibility. Although the instability discourse was sometimes contested by the professionals, sometimes, as in the extract above, it seemed that once it was invoked, it made it more difficult for the clinicians to examine their practices critically.

Arthur Frank (1995:6) has argued that in medical care a person "not only agrees to follow physical regimens that are prescribed; she also agrees, tacitly but with no less implication, to tell her story in medical terms." Similarly, the instability discourse invited many patients to adopt, or "inscribe within themselves" (Foucault, 1991:203) an understanding of their distress as a decontextualized illness out of their control:

Christine (patient): So I lived in a [psychiatric center] but went to school during the day (.) but then my illness got out of control and I couldn't be in high school any more so I (.) quit and became a day patient.

Interviewer: You said it got out of control?

Christine: Yes.

Interviewer: How, well, what does that mean?

Christine: Erm, my illness become stronger and stronger and then boom! It exploded.

Christine, IV, p. 5

In Christine's account the illness is vested with principles of explosive power, whereas Christine becomes a passive repository, whose actions, thoughts and feelings are controlled by the illness (Barrett, 1996) – a narrative in accordance with the instability discourse. This portrayal serves to construct her as a clinical object, which may make it difficult to claim a status as a social subject at the same time (Speed, 2006). Other patients talked explicitly about the implications for their sense of self and subjectivity associated with a self-narrative in accordance with the instability discourse.

Interviewer: What I was thinking about was just whether [...] the meetings you've had, if they've influenced the way you view yourself?

Anna: Well, that, I believe so because I've got to know myself better, but I'm happy that I've met people [other patients] who feel the way I do, because if I hadn't met anyone who was like me, then I think psychiatry would quickly have turned it into, or I would feel [...] that it was me that was schizophrenic [...] that is if I've had it since childhood, and the course is chronic, well (.) how could I ever know what is me? Is it when I take the symptoms away, that the rest is me, or would that only be side symptoms, or what? (.) well, you can almost turn anything into symptoms [...] when you come out and meet some other people who are like you, you don't feel wrong all the time, you don't feel like a diagnosis.

Anna, IV, p. 17

For Anna the psychiatric care has on the one hand helped her to “get to know herself better” but on the other it has made her insecure of the boundaries between her unstable “illness” and her identity. Thus, she touches upon a core ambivalence that many psychiatric patients experience with the construction of diagnostic identities (Tucker, 2009). On the one hand, the psychiatric models provide her with what appears to be an explanatory tool for making sense of her distress; on the other they seem to largely strip her of a sense of identity and agency. For Anna, the antidote becomes meeting other people who are like her, with whom she can negotiate an identity as a social subject rather than “a diagnosis”. Her statement that “you can almost turn anything into symptoms” points towards a colonizing quality of the discourse; she can never be sure that the instability is limited to only a specific part of herself and that it will not spread. It becomes a source of continuous self-monitoring and self-pathologization. This construction of her distress thus extends from the formulation of a descriptive psychiatric label and becomes an existential dilemma. As she says: how could she ever know what is left of her when the symptoms are taken away?

Like several other patients, Anna describes a weakened sense of agency and identity as a result of the instability discourse. A weakened sense of self, or “self-disturbances” are well-documented in psychiatric literature and are often considered a core pathology in illnesses such as schizophrenia (Sass & Parnas, 2003). However, Anna’s statements indicate that her insecure sense of identity may rather be understood as derived from a discourse that constructs her as a repository of unstable forces, and not from the initial mental distress that she experienced. In this way, the construction of her distress as an unstable intrinsic force at least did not appear to be beneficial for her sense of agency and identity.

The discourse of “really ill”

The second discourse we have identified may be called the discourse of “really ill”. It draws on an idea that some patients are more ill than others, but also on a notion that some are more “genuinely” or “authentically” ill than others. In the following extract the nurse Catherine describes one of the patients who were considered “really ill”.

Catherine says that she is very fond of the patient Patricia and that the researcher (AR) ought to ask anyone in the team, they will all say the same – there is something special about her and all the other “real schizophrenics”, the *really ill patients*. Catherine says “Patricia’s fantastic. I’m sure you’ll notice the same when you meet her. She makes you want to care for her. Just to get a tiny insight into her life and to get to know her a bit, it’s amazing. It’s the same with all the real schizophrenics”. AR asks her what she means with “real schizophrenics”. She answers, “Well, the heavy, heavy, heavy ones.”

P/O, p. 143-155

Not all patients with a schizophrenia diagnosis were described like Patricia as “real schizophrenics”. In this way the category seemed to suggest more than the patient presenting the appropriate symptoms or having a diagnosis of schizophrenia. The nurse Catherine felt there was something special about Patricia and the other “really ill” patients that she found difficult to explain, namely a certain enigmatic quality that spoke to her and the rest of the team. The patients who were described as authentically “really ill” were often patients like Patricia, whose problems seemed clear-cut psychiatric, and who

somehow managed to achieve a balance in which they could secure the professionals' continuous interest. In both settings of the field work, many professionals explicitly stated a preference for patients whom they considered to be "really ill", echoing the findings of another mental health ethnography in Denmark in which the professionals stated a preference for the patients they called "really wonderful schizophrenics" (Schepelehn Johansen, 2007:36).

Although the specific position as "really ill" was often offered to patients who were diagnosed with schizophrenia, it seemed to be related to the presence of a general discourse on illness as either "authentic" or "less authentic" that extended beyond specific diagnoses. In an interview, the nurse Stephanie reflected on two patients' ways of doing "really ill": Susanne, who had been diagnosed with borderline personality disorder and Astrid, who had been diagnosed with periodical depression, but who was informally named "borderline" (Koehne et al., 2013) among the professionals.

Stephanie: Whether [Susanne] has been self-harming, I actually don't know. [...] But, well I do think that in reality she could be a self-harmer, but maybe in another way. There are some who do it on their inner thighs and the skin of their belly and stuff, so that you don't notice it. And it's actually those that you should treat really seriously. I'd imagine she could be one of those who hide it (.), but we say that Astrid, if she ever kills herself, I'm sure that it will be an accident, that it will be something about the strangulation thing she does that goes wrong or something [...] I can remember, with Astrid [another patient asked the question]: "how can she show it to everyone the whole time?" Because [...] for many others there is simply so much shame, but Astrid, she gladly cuts herself in her breast, so that we can all see it [...] and wears a blouse with cleavage the next day, doesn't she? (.) And I think [unlike Astrid] Susanne is one of those (.) that may succeed with suicide.

Stephanie, IV, p. 20

Stephanie indicates that for the patients, being recognized as "really ill" was about a lot more than presenting the appropriate symptoms. Although Astrid continuously cut herself and tried to strangle herself with plastic bags, the blatant visibility of her self-harm and her apparent lack of shame became a reason why she still could not be considered "really ill" and suicidal. Her ways of doing "ill" were constructed by the professionals as something she did for show: a deliberate or demonstrative act, rather than a sign of illness. Astrid was often discussed at treatment conferences, as a patient who just cut herself as a way of craving attention, and hence should preferably not be given attention. In contrast, Susanne's general ways of doing "really ill" appeared to be

more convincing, to the extent that the nurses judged that she had the potential to cut herself, i.e. visualize illness, but in places on her body that were not visible.

One way of interpreting this is in the light of the previously discussed “moral codes” of professional discourse of mental health clinicians. The patients who were able to find a suitable balance between visibility and invisibility seemed to allow the illness to be unearthed by the professionals - offering them a position as important. When Astrid “exaggerated” her symptoms as she did, the professionals lost their position as those who could “discover” the illness in her. In this sense, Astrid posed a threat to the autonomy and clinical insightfulness of the professionals. Her actions were perceived as caricatures - and her “real” condition became blurred for both the professionals and herself.

The presence of the discourse of “really ill” may be understood against the backdrop of the organization of mental health services today. In contrast to the 1960s, when many critics complained of the excessive use of compulsory institutionalization, access to contemporary mental health services has become a scarce resource available only to those who are judged most urgently in need of help (Griffiths, 2001; Rhodes, 1995). This implies that the potential patient has the responsibility to prove that he or she requires and deserves care. Many patients seemed to be aware of the importance of visualizing illness in a recognizable way, as demonstrated in the following interview extracts:

Hanna: I [...] have the feeling whenever I’m admitted, well I’m almost scared of combing my hair and dressing properly, because then they can’t understand it, then they can’t see how ill I am inside. It’s like they can only understand what they see, that is, if you cut yourself or if you’re aggressive, or if you run around and touch the walls when you walk or something like that then they notice you, but if you make sure you keep it all inside you, then they can’t understand it, then they can’t understand how you can be so ill.

Hanna, IV, p. 14

Susanne: Yeah, I can’t even remember what [the nurse] said but she was all like “Ah, you’re not that ill” (.) but that (.) I can’t really handle that; I can’t really handle the resistance that I’ve faced so many times in psychiatry. It’s like you have to persuade them that you’re ill (.) while you’re in need of help. So you’re scared to be happy, you’re scared of having a good day (.) because what if they see it and think, “So there, she’s fine” [...] [If it happens again] I think I’ll just break up inside.

Hanna and Susanne seem to be aware that true and “authentic” illness is not only something that needs to be “inside them” - as the instability discourse may invite them into believing - but also something that should be displayed in suitable ways when meeting professionals. Just like the nurse Stephanie, they point out that the discourse of “really ill” requires a specific form of visibility; the illness should be visualized and made accessible for the professionals to observe and interpret. Hamilton & Manias (2007) have shown that psychiatric nurses rely at least as much on their observational skills in judging psychopathology and mood states as on their skills in communicating with patients. They demonstrate that psychiatric inpatients are constantly subject to gazes and scans that occur both explicitly and subtly. Hanna and Susanne seem to have acknowledged this aspect of psychiatric practice; they are aware that they cannot rely on being recognized as in need of care solely by expressing such a need verbally. Their need for care must also be continuously visualized in a recognizable manner. For Hanna and Susanne, doing “ill” in appropriate ways when they’re feeling distressed and in need of care becomes crucial; although, as Susanne paradoxically points out, doing “ill” in the right way requires her to find energy and resources that she does not necessarily have. For her, the pressure to do “ill” and the feeling of a distrustful gaze judging her becomes, in itself, a source of despair.

The struggle to persuade others of illness seemed particularly pertinent among the patients whose distress was not attributed to psychosis. Many of the patients who were considered psychotic were instead invited to a relatively fixed position as “really ill”. At the same time as many patients struggled to be recognized as “really ill” there were also numerous examples of patients who resisted the position of “really ill” due to its ambivalent nature: the position did not only provide legitimacy, but also potentially imposed treatment upon the person (e.g. hospitalization and medication) and was a stigmatized position in society. This brings us to the final discourse we will discuss: the discourse of “lack of insight”.

The lack of insight discourse

Psychiatric patients' initial ideas about their difficulties often diverge greatly from how mental health professionals view them (Kinderman et al., 2006). A central task for the mental health services then become to persuade the patient that her distress are due to a mental illness which can be alleviated by psychiatric treatment. The psychiatric concept of "illness insight" entails an expectation that the patients subscribe to a psychiatric definition of their difficulties (Hamilton & Roper, 2006). It therefore becomes problematic when a patient does not accept the explanation of his or her situation offered by the professionals. In such situations, the disagreement between the two may be installed *in* the patient as "lack of insight". This sometimes resulted in discussions between professionals and patients about the nature of their problems and definitions of truth, as in the following extract of a conversation between a nurse and a patient:

Johan: It's the medications that ruin it for me. We have to work on getting rid of the drugs. There's nothing wrong with my head.

Lisa: No, but you're out of touch with reality. As such reality can be a lot of things, but the way the world works, reality is what most people perceive it to be. You're the only one who thinks that plants talk.

Johan: That is reality.

Lisa: That's your reality.

Johan: It's the truth.

[...]

Lisa: You have to admit that a lot of things happen to you and not to other people. [...] I don't know, some of it may be true. But with the plants, I know it's just you. We just haven't been able to find the right medication that will remove it.

P/O, p. 363

Johan seems to have a different view of his situation from his nurse. For Johan, there was nothing "wrong with his head" and taking medication was a problem; the medication was experienced as more detrimental than helpful. For Lisa, the question to be answered was whether Johan had been pre-

scribed the right medication, but not whether Johan needed medication at all to adjust his world view. In the conversation between the two, the problem did not seem to be that Johan had a different reality; the problem rather appeared to be that he did not want to acknowledge and take moral responsibility for the different reality. Having the right insight and taking moral responsibility for it was perceived as a road towards recovery - a road that Johan did not seem to want to embark on.

The lack of insight discourse may be said to be based on an assumption about pathology existing “within the patient” and is thus aligned with the discourse we have called the “instability discourse”. At the same time it may be said to add an extra layer; pathology becomes something that the patients have to acknowledge in order to recover. Thus, having illness insight implies willingness by the patient to work on his or her problems and to go through an individualized process of self-development. In this sense, insight implies a moral responsibility; taking up a particular reflexive relationship to the problems (Blackman, 2007). While the instability discourse largely stripped the person of agency and morality, the lack of insight discourse may be said to reinstall it in the patient. For the patients, this also seemed to imply a moral responsibility of knowing “their place”:

In the group called “psychoeducation for bipolar patients” the patient Christian is very active and comes up with new topics and advice for the other patients. Diana, the group therapist, corrects him a few times when he brings up subjects that are not on the agenda, but at other times she encourages him to continue. In the break between the sessions Diana comes up to AR and we talk about how it went. She asks ironically if AR has noticed her co-therapist. AR asks if she is referring to the nurse Mina, who is absent today, but who is usually the co-therapist in the group. Diana answers, “No, Christian. With a co-therapist like that I almost don’t need Mina.” She says that she likes Christian, but he has a hard time limiting himself. Then she adds that Christian has a terrible life history and she tells about it.

P/O, p. 196

In the group meeting, Christian appeared to have assumed the authority of a person who defines topics and solutions – an authority he did not automatically have access to from his position as patient. Diana interpreted his actions as a sign that Christian had difficulties in limiting himself, difficulties she implicitly related to his “terrible life history”. Thus, Christian’s desire to help his co-patients is not construed as a resource, but as a sign of something “inside him” that has not yet been properly processed. This seems to indicate that

illness insight does not only imply that the patients define themselves as ill, but also that they recognize that the professionals have deeper insight into the illness - and acknowledge the need for professionals to define the implications of the illness (Blackman, 2007).

Some professionals reflected on the ethical aspects of having to persuade the patients about their lack of insight. In the following interview the nurse Francis reflects on an episode with a patient whom she partly succeeded in convincing that his perceptions of being controlled by an abstract organization were in fact due to his illness.

Francis: ...had I become too eager, too eager in thinking: now I will help you even though you haven't asked to be helped [...]. At one point he told me that he would never have survived the twenty-five years if it hadn't been for the organization. When they came they saved his life, so what had I done by trying to remove them [...] (.) that's one of the few times when I look back and think: maybe it wasn't totally good what I did (.) and you never really get an answer to that, and that's the downside of being in psychiatry, because there's no right or wrong.

Francis, IV, p. 2

Francis' statements indicate that the lack of insight discourse sometimes required the professionals to treat the patients in ways they did not always feel comfortable with. Francis' statements can be read in line with some of the challenges to the illness paradigm from service user and survivor movements, which stress that it is important to accept as valid the experiences of delusions and hearing voices (Blackman, 2001; Harper, 2004). However, her reflections do not extend beyond her own personal ethics, and she leaves unchallenged the general notion that patients lack insight and that it is the duty of professionals to provide insight for them. Instead, she relates her reflections to a general assumption about the mental health services as a place where "nothing is right or wrong" – as an almost free platform for action, ungoverned by norms and expectations. Contrary to this assumption, our discussion here indicates that the discourses operating in the mental health services lay down relatively strong norms that influence how the patients and professionals could act and think. Perhaps these norms had become knowledge taken for granted and were difficult to spot for the professionals. However, for many of the patients, they seemed to be more visible:

Noel: If you come and say “there’s nothing wrong with me” then that’s a symptom that you’re ill [...] they wanted me to come to a doctor’s appointment and then I was supposed to acknowledge that I was ill (.)

Interviewer: Mm, and what happened?

Noel: Then I just said, “I’m not ill” [...] and then they said, “that’s your illness” (.)

Interviewer: And what did you think about that?

Noel: I was speechless I must say, because it’s like punching a pillow [...] can’t you see? You’re totally at their mercy and in their power.

Noel, IV, p. 10

Noel’s statements tell a story of not having been understood and seen the way he expected to be. As Barrett and others have pointed out, the stories told to clinicians by psychiatric patients are certainly heard and listened to, but the process of hearing is filtered through diagnostic and psychiatric lenses, molded to fit pre-existing categories (Barrett, 1996; Swartz, 2005). Noel’s insistence on not being ill becomes construed as yet another sign of illness and he is urged again to interpret his rejection of psychiatric definitions as a symptom of illness. As Noel describes it, “like punching a pillow”, no other discursive repertoires or positions are made available for him than the one he opposes. In this sense he is stripped of possibilities to say anything meaningful about his situation, because his statements are only ascribed meaning in a discourse that he does not identify with.

It is interesting to see how Noel is well aware of the existence of a discourse of “lack of insight”. In contrast to the nurse Francis, the psychiatric setting for him is not a place where there is “no right or wrong”. He knows that there is a “right” interpretation, but he does not agree with it. Noel’s statements reveal that he understands the rules of the game in which he is caught up - rules that demand that he assumes a specific position in order to become a recognizable psychiatric subject. For him this means that his own explanations do not become legitimate. We will now return to the patient Johan’s reflections on his conversation with the nurse Lisa, which we discussed in the beginning of this section.

Johan: But they don't believe me when I tell them that the plants follow me around and the flowers, and all that and the trees (.) and dammit, it's the truth [...]

Interviewer: What, well, have you said this to anyone from psychiatry, these things?

Johan: Hell no, they'll think you're mad as a hatter, hahaha.

Interviewer: They will?

Johan: Hahaha, you'll get locked up, hahaha. No, I'll just have to learn to live with them following me around. [...] I've never told anyone before yesterday. And she didn't believe me either, the nurse.

Johan, IV, p. 6

Johan is aware that his experiences may be rendered illegitimate by others. He expected not to be believed and he was afraid that revealing his thoughts would lead to an intensification of a treatment that he did not believe in. This was why he ordinarily chose not to speak about his mental distress. For him, the proof that he was right not to talk about it comes when he finally makes an exception and tells the nurse Lisa about what he perceives to be the problem - and she, as he predicted, does not believe him either. From now on, he knows that he has to consider strategically how to appear in front of the professionals in order to have a say in his treatment.

Conclusion

The paper has illustrated the complexity of “illness talk” in the psychiatric settings we studied. We have demonstrated the ways in which different discourses that featured in the settings brought to the foreground particular ways of “doing ill”, rendering inauthentic or problematic other expressions of mental distress. This implied that the patients were required to develop a finely-tuned and complex sense for the discourses and to make strategic considerations as to how to appear in front of professionals if they wished to have a say in their treatment. In this sense, the extent to which the individual patient was positioned as ill seemed to depend more on his or her ability to adapt to the discourses and to the psychiatric setting, rather than on any objective diagnostic criteria. The emphasis on “real illness”, illness insight and explosive

instability found in this study is hardly particular to the settings of our field-work, but is likely found in other mental health institutions. At the same time, some illness constructions may work as a type of “reversed order” in relation to the rest of society. For example, the relatively high and attractive status inherent in the position of “really mentally ill” in the settings may be contrasted with the stigmatization inherent in such a category in broader society. There may therefore be significant risks of disempowerment if patients learn to strive for and embrace a position as a “really ill” subject. This underscores the importance of studying discourses of illness as negotiated and managed contextually and locally.

As noted in the introduction, illness discourses have implications for how patients may be actively involved in the treatment. We now turn to a discussion about how the policy and practice of service user involvement in the mental health services can be understood in light of our results. Service user involvement is often construed as the practice of listening to and respecting the individual patient as well as allowing him or her an important say in the treatment. However, this paper indicates that it is when patients’ experiences and perspectives are formed and molded to fit particular psychiatric narratives that the patients may be recognized as authentic and legitimate persons who can be involved in the treatment. In this way, psychiatric practice seems to rely on some relatively fixed ideas about the characteristics of the patient who can be involved. Firstly, it is a patient who assumes a specific reflexive relationship to his or her difficulties, one who recognizes a dependence on mental health professionals and psychiatric definitions. Secondly, it is a patient who is able to display his or her distress in a fine balance between visibility and invisibility in a manner that allows her to appear as a subject and object at the same time. A patient who becomes too visibly “really ill” and positioned as caught by an inner instability risks being positioned entirely as an object. On the other hand, a patient who acts too much as a subject with volition and intentionality may be positioned as not authentically “really ill” and thus risk exclusion from psychiatric care. Thus, the practice of service user involvement seems to rely on the patient managing a fine balance which allows her to be both object and subject, independently reflexive and dependent at the same time. This balance is difficult to manage, and as we have seen many patients seem unable to do so.

At the same time, the discussion indicates that the discourses were not all-embracing. There were some oppositional practices towards them from both

patients and professionals. Taking service user involvement seriously would mean allowing for a loosening up of the discourses we have described, where more subject positions could have access to legitimate and rightful participation. This would imply reflexivity and increased attention to the local, contextual and constructed nature of psychiatric narratives - as well as sensitive responsiveness to perspectives that diverge greatly from traditional psychiatric understandings.

Article 3: “I would like to retain your compulsory treatment, is that alright with you?”: Discursive constraints and possibilities for user involvement in day-to-day mental health work

Abstract

The practice and policy of user involvement have become a major political aim in the mental health services. This article approaches the topic by studying mental health professionals' day-to-day practices of user involvement in the context of concrete meetings and relationships with patients. The article draws on data from an ethnographic study of two psychiatric institutions in Denmark to explore when and how it became possible for the professionals in the study to involve patients' perspectives in the treatment. It is shown that many dominant discourses in mental health care work as constraints against user involvement; for the professionals user involvement therefore involved a complex balancing act among contradictions. This balancing act was difficult and demanding, particularly when it came to involving patients' ideas about the origins of distress. It is argued that if the impact of user involvement initiatives is to extend beyond tokenism, mental health professionals need to be supported in their endeavors to involve patients' perspectives by a system which allows for more loose and complex definitions of mental distress, patienthood and the professionals' "roles".

Introduction

The idea of involving users and their perspectives in the delivery and planning of mental health services has been a widely recognized position among policy makers and politicians the last decades. User involvement and participation has been inscribed in the legislature and official treatment documents of the mental health services in many Western countries. Many patients have similarly embraced the idea, sometimes forming organizations with the explicit aim of promoting involvement on different levels of the organization

(Bowl, 1996; Connor & Wilson, 2006; Petersen et al., 2012; D. Rose, 2003). There is also evidence to suggest that many mental health professionals are positive to the idea of user involvement (Anthony & Crawford, 2000; Summers, 2003). However, although user involvement and a patient-professional relationship based on collaboration and partnership have been an aim in mental health care, there is a growing amount of research and critical discussions which call into question the extent to which patients and their perspectives are actually being involved in the treatment (Bowl, 1996; S. M. Hodge, 2009; Pilgrim & Waldron, 1998; Roberts, 2010). When policy makers, patients and many professionals alike seem positive to the notion of user involvement, why does the extent to which it actually occurs seem so limited?

While rarely empirically researched, constraints to user involvement have been the focus of theoretical discussions. Some of these have emphasized the power and knowledge structures inherent in psychiatry as obstacles to active patient participation and involvement. Thus, Roberts (2010) has focused on the language and diagnostic categories of psychiatry to argue that active user participation is constrained by the discourses on mental illness which dominate mental health practice and research. Roberts suggests that when mental illness is exclusively conceptualized as consisting of deficiencies such as a lacking sense of reality and rationality, the person with the illness is constructed as deficient. This makes the professional less prone to explore the person's possibilities for personal development and more prone to emphasize control and monitoring in the treatment. Borg, Karlsson, & Kim (2009) have similarly emphasized the medicalized assumptions about patients' problems inherent in definitions of mental illness as barriers, but propose a number of additional challenges to involving user perspectives in community mental health care. These are: the power of defining "true knowledge", typically associated with the expert knowledge attributed to professionals, allowing them to have unique control; stigmatization, negative stereotypes and micro-aggression against users outside and inside the mental health services; and a potential maximization of the "patient" role to other arenas of life associated with de-institutionalization – turning patients' own home into arenas of potential control and regulations. Pilgrim & Waldon (1998) have additionally identified as barriers for user involvement in mental health care the creation of "quasi-markets", resulting from an increasingly consumerist model of mental health care delivery, as well as lack of financial support for user initiatives.

While theoretical accounts have provided important insights into the macro-processes which may constrain the practice of user involvement, empirical studies on how professionals attempt to practice user involvement in light of possible constraints have received considerably less attention. A common strand of empirical research on user involvement has instead focused on professionals' attitudes to the concept of user involvement. For example, Anthony & Crawford (2000) found that mental health nurses generally value the concept of user involvement but consider it to be problematic in specific situations, due to limited resources, individual differences between patients and limitations in nursing care. Similarly, Summers (2003) found that psychiatrists differ in terms of the degree to which they endorse the concept, but that many find it useful, at least to a certain extent. While studies on professionals' attitudes offer insight into the reflexivity of individual professionals in relation to involving patients, little insight is provided into how professionals actually practice user involvement, and the barriers and possibilities that emerge in the process. This article presents a more contextual approach, in which practices of user involvement are studied in the context of specific patient-professional relationships and interactions. The data presented are based on a larger ethnographic study on two mental health institutions in Denmark. In previous articles (Ringer, 2013; Ringer & Holen, 2013) I have focused on the barriers to user involvement as these may be experienced by patients. In this paper, I focus mainly on mental health professionals and present an empirical account of the possibilities of practicing user involvement in the professionals' day-to-day "discursive doings" (Middleton & Uys, 2009) when meeting patients.

The study and its theoretical framework

The cases presented in the paper are derived from a three-month (240 h) ethnographic study conducted at two psychiatric institutions for adults in Denmark in 2011. Situated in two medium sized towns in Denmark, one of the institutions was an outpatient clinic and the other a "closed" inpatient ward. The study was carried out in Region Zealand, which in 2009, had launched the three year project "User-led Psychiatry" (Brugerstyret Psykiatri), with the aim of raising awareness among professionals, and implementing a higher degree of user involvement. User-led Psychiatry involved a number of local

workshops, theme-days and other educational initiatives to promote working towards active involvement of patients. In continuation of the project User-Led Psychiatry, an initiative towards establishing a PhD-project which focused on language and user involvement was developed. This PhD-study is the backdrop of this article.

The fieldwork of the study involved participant observation of everyday life at the institutions: of meetings between professionals and patients, staff meetings and periods of idle time. Semi-structured individual interviews with 13 patients and 11 professionals lasting between 0.5-1.5 hours were conducted. A principle of maximum variation (Polkinghorne, 2005) was applied in selecting participants for observations and interviews; professionals and patients positioned as diversely as possible in the organization were invited to participate in the study. Notes were recorded during or immediately after each participant observation and they were elaborated into extensive fieldnotes later the same day. All interviews as well as some observations of patient-professional meetings were additionally audio-recorded and transcribed verbatim. All names of participants are pseudonyms and information which may compromise anonymity has been changed.

The analysis was theoretically informed by a version of discourse analysis inspired by the work of Foucault (Willig, 2008). Such an approach is based on the notion that discourses construct the objects and subjects of which they speak. Since discourses make available certain types of subject positions (e.g. doctor, patient, mentally ill) they are implicated in the exercise of power and knowledge. Within any system or institution, power is exercised through the language and practices employed, which become naturalized as taken for granted assumptions. The dominant discourses further preserve their power by keeping competing discourses in a subjugated position. In this way, language, power and knowledge are intrinsically intertwined. However, discourses and power/knowledge structures can also be resisted. As Foucault (1980:142) writes: “there are no relations of power without resistances [...] It exists all the more by being in the same place as power; hence, like power, resistance is multiple”. From this perspective, although mental health professionals and patients may be regarded as enmeshed in a web of power, they also have the possibility to resist dominant discourses. For the purpose of the paper, I am particularly interested in the strategies and multiple ways in which

mental health professionals negotiate and re-negotiate the regimes and discursive constraints which guide their work.

Definitions and degrees of user involvement

User involvement is not a uniform concept and there are many ways to define it. There are also a number of different terms used in the literature, suggesting different degrees of involvement: e.g. user participation, user control, user-led services, empowerment and user perspectives (Borg et al., 2009). The terms appear to refer to different assumptions concerning patients' roles in receiving as well as planning mental health services. For example, on a simple inspection, "user-led services" seems to refer to users being directly and actively involved in the planning, policy and development of services while e.g. user participation seems to refer to users being less influential, but rather just "participants" (ibid.). However, the differences between the terms are subtle, and they are often used interchangeably (Borg et al., 2009).

Often, what is meant by user involvement is not specified in detail, and there seems to be some confusion regarding the term in psychiatric practice and research. Beresford (2002) has argued that much of the confusion stems from the fact that there are two inherently different models of involvement: the "consumerist" model and the "democratic" model. While the two models at points overlap in terms of interests and objectives, they have entirely different roots, philosophies and ideologies. The first model stems from market forces in the state and the second is derived from liberation and grass root movements such as survivor organizations. The "consumerist" model of user involvement is closely aligned with the political right, couched in terms of "getting the product right" through consumer feedback. The "democratic approach" is linked to user and disability organizations and is inherently political - it is concerned with people having more of a say in the institutions which impact upon them. In contrast to the consumerist model, it aims at a re-distribution of power. In the context of mental health practice, Pilgrim (2005) has distinguished between a "conservative" and a "radical" approach, which bears similarities to Beresford's distinction between consumerist and democratic models. While the conservative approach is concerned with improving and optimizing services, the radical approach aims at changing and democratizing the mental health services. In this paper, I am particularly in-

terested in exploring when and how it becomes possible for mental health professionals to make motions towards practicing a democratic type of user involvement, which progresses beyond eliciting consumer feedback. Thus I wish to examine how mental health professionals in the study practiced user involvement in terms of a redistribution of authority; in terms of being attentive to and acting upon individual patients' needs; and in terms of a re-definition of their and the patients' positions.

Tait and Lester (2005) cite four different levels on which user involvement may take place: between service users in the form of self-help; between professionals and users; in the management of local services; and in planning of overall services. While I share the understanding advanced by Pilgrim (2005), that to instigate actual social change user involvement ought to be backed up by policy and programs which encourage patients to be directly involved in planning and re-organizing services, in this paper I am interested in how user involvement is practiced in the context of discursive constraints and possibilities in concrete day-to-day meetings between patients and professionals. The increasing policy focus on user involvement in mental health management has been criticized for being tokenistic and not involving any real democratic ambitions. I suggest that, although perhaps mostly in a subtle way, user involvement may still occur in meetings between patients and professionals, e.g. if some forms of power are resisted or changed in the encounter. For this purpose, I take as my point of departure the definition used in a folder on "User-led Psychiatry" issued by the mental health services in Region Zealand (Psykiatrien Region Sjælland, 2010:2) in Denmark, which defines user involvement as: "treatment [...] based on a co-operation between patient and professional, which takes as its starting point the patient's experiences and wishes" and as something which: "takes place in the relationship between patient and practitioner. It is about values in the encounter, about roles and about the concrete co-operation" [my translation]. In this paper, I am therefore concerned with the possibilities for practicing user involvement that became available for professionals in specific day-to-day encounters with patients. I will argue that many of the dominant discourses in mental health care place restraints on involving patients in the treatment, demanding that the professionals engage in a complex balancing act between contradictory discourses, when they strive to practice user involvement.

The cases used in this article have been selected based on thematic analysis, in which patients' and professionals' definitions of user involvement were grouped together and points of overlap were noted. Based on these categorizations, four areas important for user involvement emerged: the "personal professional", "standardization vs. unique needs", "efficiency vs. individuals' wishes" and "de-pathologization". These form the structure of the analysis.

The limits of authority: practicing "personal" and "professional"

Many professionals were preoccupied with what they called a tension between "being personal" and "being professional". Generally, the professionals believed it was important to keep a professional distance and not be "too private" with patients. When individual professionals stepped out of the boundaries of what was perceived as "professionalism", by being overly friendly and intimate with patients or by continuously asking them their views, they were sometimes mocked by their colleagues. Individual professionals also lamented if they had developed relationships with patients that were too intimate and could not be ended efficiently after the treatment. This understanding was cultivated by an assumption that the patients needed boundaries and would become insecure if they did not know who the professional was. At the same time, subscribing to an ethical ideal of co-operation and partnership, many wanted to avoid an all-embracing professional distance, or being a "stone-faced professional", as one nursed called it. Thus, many discussed the difficulties involved in finding the right balance between being professional and personal. As Marie, a health care worker said:

"It is a job where you can't avoid giving something from yourself as a human. If you, if you don't give anything from yourself you become one of those that the patients typically don't like, because then they notice that you are very distanced, so it's that tight-rope walking, to give a bit of yourself and take care of yourself (mm) that fine balance. That is, I don't know how many years I will be able to last here in psychiatry, but I believe you can quickly become burned out, if you don't watch out"

Marie, IV, p. 19

Some professionals said they did not like to be associated with a professional role, experiencing the boundaries of the role as a restraint for reaching out to patients. Being aware that the professional-patient relationship was produced as one of authority, many professionals said they intentionally attempted to position themselves as “personal” in order to gain a patient’s trust. One case manager²² explained: “If the patient is sitting and feeling like a patient and I’m feeling like a practitioner, we won’t make it very far”. Another case manager said: “they have to know me a bit like a person, know that sitting across them is a person who is human. But they should also be able to sense that the guy knows what he’s talking about”. In these statements, professional and personal are constructed as two antagonistic processes, “professionalism” implying a distance to the patients, “being personal” implying intimacy and closeness. Navigating in between these two poles, most professionals struggled to find some middle ground. It seemed as if neither “too professional” nor “too personal” were attractive positions. The professionals’ attempts at managing “personal” and “professional” are echoed in Lipsky’s (2010) classical study on front figures in social work. Lipsky found that many front line professionals experienced a dilemma in being placed in an institutional frame which demanded a specific standardized bureaucratic form of interaction, and simultaneously living up to the ideals of meeting an individual person in a unique situation in the settings. For the professionals in this study, one way of managing the institutional frame was to position themselves as oppositional to the system they represented, as Magda, a nurse, said:

Magda: Well, there are a few times when you (.) can tell [patients] that the systems are very rigid [...] I say (.) that’s bloody not good enough from the municipality and they should really (.) I had really counted on you getting through with it. So I use myself a lot and what I myself, um (.) what my own (.) opinions are, without it becoming the norms, but more my own opinion about stuff. So you can really show (.) that you disagree with your own system or the municipal system or the government or something [...] it gives more equality I think, to meet that way (.) so they can see a bit more of what I am, so I just don’t bring a very professional, um (.) gaze or façade, because I’ve seen that too, colleagues that are very, who never say anything about themselves or never say what they think (A: okay) and that (.) I don’t want to do that.

²² Case managers are contact persons for patients, with whom a patient has the most frequent contact. They can be e.g. nurses, health care workers, occupational therapists or social workers.

Magda constructs herself as disavowing the “role” of the stereotypical professional, by positioning herself in opposition to the system she represents. In this way, she similarly constructs “personal” as in opposition to “professional”. She points towards a fundamental contradiction inherent in the positions of the professionals: on the one hand they are part of a system that exercises visible power over patients (e.g. by making decisions for them), on the other, the ideal commands a kind of egalitarianism, emphasizing equality, co-operation and partnership. Barrett (1996:28) has noted how the official historiography and self-narrative of contemporary mental health services tend to construct custodialism, coercion and authority as a problem of the “dark past” - and yet how they are still central to the contemporary functioning of psychiatry. Constructing a distinction between her “personal opinion” and the stark rules of the game allows Magda to disidentify for a moment from the authority inherent in her position as representative of the system. In doing this, she may be said to make an identity claim I have previously referred to as “least staff” (Ringer, 2013). Such an identity was attractive in some contexts, in that it represented a possibility to reach out to patients in ways that deflected the visible power of the position of “professional”.

In situations of explicit patient-professional conflict, however, the difference in authority became unavoidably visible. Particularly the mandate to make decisions on behalf of patients and to practice coercion and restraint seemed to be a point of discomfort and difficulty for many of the professionals. This was especially the case at the ward, where detention and sectioning were relatively common. One health care worker commented: “The patients don’t understand that it is also hard for us to use coercion - that we can also get frightened and feel bad about it”. Some professionals at the ward complained about feeling more like “prison wardens” than providers of care. This conflict between on the one hand a professional ideal of partnership and “being good” (Rhodes, 1995:142) and on the other using restraint and working against the will of an individual, at times nurtured paradoxical effects. During an inspection of a reluctant patient for a re-assessment of his restraint, one doctor interviewed the patient for a few minutes and subsequently asked: “Well, I would like to retain your compulsory treatment, is that alright with you?” The oxymoronic quality of this question reflects the contradictions that were a central feature of the professionals’ day-to-day work.

Another point of patient-staff conflict revolved around psychotropic medication. There were numerous instances in which patients either refused medication or wanted substantially less (e.g. anti-psychotics), or, contrary, wanted significantly more (e.g. benzodiazepines) than the professionals thought was responsible. The professionals who were not involved in the distribution of medication, such as social workers, occupational therapists, psychologists, physiotherapists or psychotherapists, could avoid taking part in these conflicts. One such professional was Rebecca, whose background did not grant her the right to distribute medications. She explained that not having to medicate at times meant that it was possible for her to be positioned as “least staff”:

“I differ from the nursing staff in the sense that the patients don’t have the contact around medication with me, which sometimes gives another alliance [...] I have often heard the patients ask me: “Where are the staff?” um, so I’m not thought of [as part of the staff] in the same way (.) so sometimes you get to know some other stuff about the patients, sometimes they tell me other things than they tell the nursing staff (.) um, I think often the patients equate nurses, [health care] assistants and doctors (.) and they are like the staff. Um, and I’m allowed to be on the sideline (.) and bring some other things in, and like, a bit different way of doing things. And then I’m maybe not completely perceived to be part of this, slightly dangerous decider group (mm) if you can say it that way that, um, that I can be the one who maybe does the kind of fun stuff [...] so I think I get a slightly different role, my experience anyway is that I get a slightly different role than being staff”

Rebecca, IV, p. 7

Whereas Rebecca related her identity-claim as “least-staff” to her not distributing medication and therefore not being part of what she calls the “decider group”, in my observations I have noted an additional way in which it would appear that Rebecca negotiated a “least-staff” position: when she was alone with the patients, she tended to engage in the informal practice of cursing.

There are four table tennis bats and I’m in the game together with Rebecca and the two patients Amanda and Isabella. Maya, another patient is watching us play. Isabella and Rebecca laugh a lot together. Rebecca curses a great deal, when she misses the ball or jokes around. She keeps saying “goddamn” and “bloody hell”. The patient Amanda shouts playfully: “Ey, where did you get that language?” Rebecca laughs and says that it comes from this room and

she makes a gesture towards Isabella and Maya. Maya makes a funny offended face, crosses her arms and says: “Ey, it’s not from me anyway!”

P/O, p. 251

At psychiatric wards, the boundaries between leisure time and treatment are loose and difficult to spot. Patients are potentially at any single moment positioned as “being treated” and the professionals are potentially at any time positioned as “treating” or “observing” them (McGrath, 2012; Ringer, 2013). In such a panoptical space, a pastime such as playing table tennis could be construed as a rehabilitation activity aimed at restoring the patients to normal functioning, or alternatively, as a way of normalization by “distracting” them from distress. However, by cursing, Rebecca seems to undermine this potential disciplinary function of the game of table-tennis. Instead, she opens up for inscribing it into a discursive genre other than that of a therapeutic interaction - and challenges the boundaries of her position of authority. Amanda’s playful remark about Rebecca’s “dirty language” appears to be both an endorsement of Rebecca’s identity claims and a subtle reminder of the otherwise apparent differences in their positions. Rebecca’s reply that she has learned the language from “this room” picks up on Amanda’s call and seeks to smooth out her own position as “other” from the patients in the room.

The professionals’ endeavors to construct some wiggle room may be regarded as ways of re-negotiating the position of authority over patient that they occupied. This can be couched in terms of Foucault’s (1980) view of power as never linear or top-down, but working in a network. As Foucault (1980:16) notes: “everyone is caught, those who exercise power just as much as those over whom it is exercised”. Foucault’s well-known statement bears resemblance to a maxim often repeated by the professionals at the mental health clinic in this study: “If the patient is sentenced to treatment, I am sentenced as well - to taking care of the patient”. It seems that in the instances when this mutual penal relationship was destabilized, it became possible for the professionals to re-negotiate their position of authority – and, at least for an instant, to open up a different distribution of power. One such episode occurred at the ward during an outing to a garden adjacent to the ward, which unexpectedly ended elsewhere.

We walk out through the exit but cannot locate the garden that the health care worker Marie said she would lead us to. The new premises of the ward

are still a little unknown to the professionals. We instead find a bench on the grass and settle around it. Marie and some of the patients start talking about music. Marie says that she used to like metal music, like Judas Priest. Her interlocutors become a little surprised, they like metal music too - especially Hanna and David. Then they discuss psychiatry. Marie says: [...] "I remember when I was a health care student, it sometimes seemed as if the life of the staff was all pink. But what do you prefer, if we tell you when we're having a bad day, or not? We don't want to load you with our problems." Hanna says she prefers when the professionals are honest so they should say what's on their mind to make the relationship more equal. Rose says that she's had experiences when the staff just "offloaded" and that wasn't good either. Hanna says that she really likes the nurse Mike, who was at the ward yesterday, that he told her personal things about his childhood. She says it's important that the staff listen to the patients as "we have sensible things to say".

P/O, p. 305

While the excursion was originally headed by the health care worker Marie, her authority as the "leader" of the excursion was destabilized when she failed to find the garden. And so Marie and the group of patients shared a common experience: none of them were able to find their way around. This opened up an informal space, where a repertoire of topics from everyday life could be drawn on. In discussing music preferences and finding commonalities, it becomes possible for Marie to practice "personal" - and even surprise her interlocutors, since a taste for metal music is perhaps not usually associated with the position of a psychiatric professional. Consequently, she is able to share with the accompanying patients the concern that preoccupied her and many other professionals: the extent to which professionals can allow themselves to be intimate and reveal details from their own life. In doing so, she positions the patients as valuable interlocutors whose opinions are important for delivering a good service.

Furthermore, by asking the present patients what they prefer, she admits to not being in the know. These types of conversations, concerning how to act with patients, would often take place among professionals in the absence of patients. However, the discursive context and the informality of the situation appear to make it possible for Marie to share her concerns with the patients. She offers them two choices: a preference for whether the professionals should reveal if they are having a bad day or a preference for the opposite. In this way, she may be said to open up for a type of "consumerist" model of

user involvement. Her questions resemble, to some extent, the forced-choice format of consumer satisfaction studies with predesigned answers. While the question calls for a straight “yes-or-no” answer, the replies Marie receives are far from straightforward. Hanna seems to prefer when the professionals are honest and to appreciate it even when they tell her things from their childhood, while Rose emphasizes that it is important for her not to be burdened by the professionals’ personal problems. In the process of the discussion, and almost unnoticeably, a further development occurs: the terms of Marie’s questions become subtly renegotiated by Hanna. Although Marie’s question is framed in a yes-or-no format and is perhaps primarily aimed at her using the feedback to develop “best practice”, Hanna inscribes the question in a democratic equality discourse. She uses the question as a starting point for a fundamental discussion on equality and power in psychiatry, stating that the relationship should be “more equal”. She says that the patients have sensible things to say and should be listened to more by professionals, thus implying that patients are often considered to say senseless things that should not be listened to. In this way, Marie’s question becomes a stepping stone for a discussion on the boundaries of expert power and the construction of psychiatric patienthood in general. Marie’s positioning of the patients as people with a valid viewpoint thus opened up for Hanna and Rose to share their thoughts, and thus for important reflections on patient rights and democracy to emerge.

The subtle re-negotiation of the professional-patient relationship could perhaps only occur in the context of locating a space which was produced as “other” than psychiatric; in this case, perhaps befittingly, a place placed geographically outside of the walls of the psychiatric institution. Getting lost together seemed to challenge the professional authority inherent in Marie’s position, and made available a possibility for her to practice “personal” professional. This in turn made possible the emergence of a discussion on democratic rights and citizenship.

Altogether, the examples illustrate how some professionals strived to renegotiate the power and knowledge regimes that positioned them as experts and authorities over patients. As we have seen, this was attempted by the professionals by negotiating positions that were “other” than mental health professionals, such as a position as “least staff”, and by locating or constructing spaces that could somehow be produced as “other”. It thus appeared that it

was in the instances when taken for granted assumptions and positions were somehow changed, inverted or transformed, however slightly, that patients' perspectives could be embraced in a more open manner.

Sneaking standardization and complex diversity

Being subject to administrative standards and benchmarking, in both the out-patient and inpatient settings, it was important for the professionals to discharge the patients or to end the treatment quickly, efficiently and according to set expectations. Administrative norms had been issued on how long the patients should receive treatment and on how a typical meeting with a contact person should take place. A set of standards derived from a national model, the Danish Quality Model, published at fixed intervals and the professionals were expected to implement these in their practice. The standards concerned almost all aspects of work, from how the professionals should wash their hands, through what they should ask patients during the first meeting to how they should store and distribute medication. Additionally, there was a number of teaching materials that the professionals were expected to use in standardized psychoeducation, i.e. patient education about the essence of psychiatric illness. The focus on standards and efficiency was relatively new in the settings, but had increasingly come to dominate the professionals' space. Thomas, a health care worker, said, illustrating the fears and frustrations of many professionals:

There's more and more standardization. More and more rules and control and uniformity. It has come slowly, sneaking up on you. In the beginning we were just practicing charting all our meetings with patients, like a preparation. Now we have to chart them for real. And in the future not living up to the norms will mean rounds of layoffs.

P/O, p. 44

Some professionals complained that the standards had little to do with the type of work actually being carried out. A frustrated doctor remarked that the standards required him to make a treatment plan after two meetings with a patient: "It's nonsense! Would you say that I would know you after having talked with you for two hours?" This type of resistance towards standardiza-

tion and the increasing focus on efficiency was commonplace in both settings. The standards which increasingly “came sneaking up” represented a threat by broadening the disciplinary space that made the work of professionals more “visible”. From the professionals’ point of view, rather than aimed at improving quality of care for patients, the standards were an exposure of *them* (Rhodes, 1995:115). Indeed, the standards and the surveys conducted at regular intervals were aimed at revealing the extent to which the professionals were doing their work “properly”. Thus a principle of “omnipresent surveillance, capable of making all visible” (Foucault, 1991:214) may be said to have permeated the institutions, subjecting the work of the professionals to “compulsory visibility” (Foucault, 1991: 187; Rhodes, 1995: 115). Additionally, the standards made it increasingly difficult to make professional judgments related to unique patients, standardizing the process according to a set norm. In this way, the standards sometimes functioned as a direct obstacle to accommodating individual patients’ needs.

However, from the professionals’ point of view, the standards could also to some extent be ignored, mocked or subverted into a means of protest (Rhodes, 1995). When this latter function applied, the standards could be turned into an ironic commentary on the discrepancy between the idealized and de-contextualized image of psychiatric care conveyed by the standards and the “reality” of the work life of the professionals. This was especially evident at the clinic, where the presentation of new standards during the morning meetings was most often received with mockery and irony. One time, a group of professionals gasped in exasperation when the team leader read aloud a standard requiring the professionals to test schizophrenic patients for the risk of suicide by the help of standardized tools. This, they said, could simply not be done with the amount of patients they had, which amounted to approximately 300. The professionals talked about finding “loopholes” in the standards in order to continue to provide the same care and quality as before. Some professionals additionally subverted or “bent the rules” by sometimes outright refusing to follow administrative standards in situations when they sensed this would interrupt contact with a patient. For example some professionals allowed the patients or their relatives to smoke when the professionals came for home visits, even if this was not allowed. A doctor remarked that the standards at times demanded that she ask the patients irrelevant questions. When asked whether there had been situations when she felt this was

the case, she chuckled: “No there haven’t, because then I just haven’t asked the questions, hehe”.

The standards were built on an idealized notion of psychiatric work, emphasizing systematic work and thoughtful planning, which indeed had little in common with the actual work being carried out – which was much more fuzzy, complex and hectic. Quite often the standardized tools the professionals had been given did not fit the situation at hand - and so they had to attempt to find a way to make them fit. This was also the case with the type of authoritative knowledge concerning the patients constructed in the tools developed for use in patient education. The following discussions took place during two sessions of individual psychoeducation, in which Diana, a case manager at the clinic, made use of a set of standardized PowerPoint slides.

Diana turns the screen on and a projected slide lights up. It says “Welcome to education in schizophrenia”

Diana: the first signs that one is in the process of developing the disease...
[she reads from the screen] “anxiety in social situations”

Paul: I’ve never had that. If anything, I’ve been anxious of being alone.

Diana: [continues reading]: “lack of interest, reduced sense of desire”
[lystfølelse]

Paul: When I was ill I became tremendously interested in astrology – I thought getting a better knowledge of horoscopes would be a solution to many of the world’s problems. I really wanted to be the best astrologist. I also became totally preoccupied with Jack the Ripper. It was funny [laughs]

Diana: Wasn’t it frightening?

Paul: No, I wanted to become a king in the astrology milieu. Cure sick people.

Diana: That wasn’t maybe very realistic

Paul: No

Diana: It was good that you got some medication.

[...]

The screen says: “co-operation with relatives”

Diana reads this aloud and asks: Do you think they’d be interested in coming in for a meeting?

Paul: You can give them some material, but I don’t think they’re interested...

Diana: How do you think it affected your family when you became ill?

Paul: Well, offhand I don’t know if anything big happened. But we didn’t have contact for a long time, so I don’t really know.

Diana: Do you think they missed you when you weren’t in touch?

Paul: My parents got really pissed off. They still are. It’s like they think it was some terrible treachery [that I got ill]. I don’t think anyone could change that. So that way it did affect them. And afterwards it was like they had to set me straight. It’s because they think I’m weak. They don’t like weak people.

Diana: You’re not weak just because you have an illness.

Paul: No, but they don’t really get that. My family doesn’t really get me.

Diana flips the screen. It says: “The relatives are the ones with the greatest knowledge about the patient”

Diana: well, yeah, they can often be a support.

P/O, p. 79-80; 109-11

Paul’s narrative does not match the authoritative text presented in the slide show. He has not felt anxious in social situations; rather than experiencing a lack of interest, he experienced an elevated interest in certain activities when his distress developed. Similarly, the slide which claims that the “relatives have the greatest knowledge about the patient” - rather than supporting and expanding the narrative about a family conflict - becomes an unwarranted and inaccurate interference. The slideshow thus constructed a specific version of “psychiatric patient” and “schizophrenic”, which, as became evident, did not fit with Paul’s lived experiences. The construction was one of a standardized linear “course of illness” with predictable “symptoms” and “outcomes” developing independently of social contexts and relationships with other people. The slide statements were constructed as undeniable facts, disregard-

ing the multiplicity and diversity of experiences of distress among different people. For Diana, this posed a dilemma: most likely she would have liked to present an account which would help Paul make sense of his experiences and normalize them - but in fact, the slides appeared to do the opposite. When Paul's narrative cannot be captured by the authoritative voice of the psycho-educational slides, she attempts to open up for a discussion of Paul's own experiences, but is restrained by the fact that she has to go through all the slides. She needs to "make the standards fit" and thus is obliged to cut Paul's narrative short by rounding it off with remarks such as that it was good he got medication and that the family often can be a support - well aware that this does not seem to be the case for Paul.

This example demonstrates a difficulty that some professionals were also acutely aware of: standardization inevitably constrained the ways narratives and processes of sense-making could be constructed in meetings between patients and professionals. The standards and standardized tools gave the dominance of psychiatric "expert" discourses a tangible and unquestionable form. In this way, they were in themselves contradictory to the ethical ideal to approach the patient as a unique individual. As one doctor said:

Tina: the more things we standardize and say "well this here, we need to do this, this needs to be fulfilled" the more constraints we place on where a conversation [with a patient] may move towards, and that is what I perceive to be the big problem with it. It's not that we have to secure quality, it's not that we are examining people, but it's the inherent limitation which makes us, at least sometimes in some instances, move towards something other than what actually matters the most for the patient

Tina, IV, p. 7-8

The doctor constructs the standards as an obstacle for contextual initiatives and for approaching the person as a unique individual with wishes and needs extending beyond those of the standards. In relation to the discussion presented in this paper, the point to be made here is not that the standards restrained an otherwise "free" space for spontaneous exploration, but rather, that the standardization presented yet another discursive constraint for the professionals, which again worked as an obstacle to acknowledging perspectives other than well-established psychiatric discourses.

The virtue of efficiency and making exceptions

The emphasis on efficiency, standardization and short treatment plans fostered a climate in which patients were expected to be “finished off”, discharged or turned out of the system as quickly as possible. This made the work of professionals sometimes seem more about managing flux, movement and change than about providing a coherent treatment effort. A health care worker defined his most important role in the following way: “When we can’t do anything more and the situation is acceptable, we have to end it. So the role is: be aware of how long we can keep making the situation better and when we can stop. [...] The resources are always limited”. I have previously (Ringer & Holen, 2013) noted that a discourse of “really ill” was present in both settings of the study, which required patients to prove that they were ill and deserving of care - and required the professionals to constantly observe and judge the degree of pathology in patients. The power of the discourse of “really ill” may be understood in terms of the regulations and efficiency demands guarding the professionals’ practices. For them, closing a patient’s case became a virtue in itself, and as soon as a patient was judged “stable”, “habitual” or somewhat well-functioning, the professionals had to start thinking about cutting the process short. In both settings many professionals emphasized that they provided a treatment which, as one nurse said, resisted “clingy care” which infantilized the patients and was overprotective of them. Another nurse stated more bluntly that she was harsh and strict with the patients and had to be, so that they did not become overly dependent. This philosophy was presented as in contrast to the overprotective and inefficient attitude of traditional psychiatric practice, which the professionals saw as shielding the patients away from society - making them fragile by placing them in psychiatric care for prolonged periods of time.

While the professionals’ focus on efficiency and on discharging patients may be seen as an acquiescence of the demands of management and standardization, there were also examples of the professionals resisting these demands for certain patients. For example, one patient, who perpetually had nightmares about losing her contact person and having her treatment terminated before she was ready, was promised by her psychiatric contact person that no matter what, she would be allowed to continuously receive psychiatric care for at least half a year and perhaps a full year. At other times, the professionals had to struggle to convince their colleagues that a particular patient should

be allowed to continue in treatment. The following scene at the ward represents such an exercise in persuasion:

A group of professionals are sitting in the staff room during a break, chatting. There is a natural pause in the talk. The health care worker Sandra looks up at the white board, which contains information on all patients at the ward and asks: "Shouldn't Laura be discharged soon?" Marianne, who is Laura's primary contact person answers that Laura is still "feeling really bad". She just keeps up a façade when she's out among the others. The nurse Sylvia comes in and asks who they're talking about. Marianne explains that they're talking about Laura and that Laura's feeling really bad and has difficulties with meetings [...] Sylvia comments that it's true; she also thinks Laura's looking worse. She doesn't see her friends as often [...] Marianne says that the doctor is of the opinion that Laura has a depression - and "after all, that takes time". Laura takes Cymbalta, maybe also something else. Marianne says that she is much more worried about Laura than about another patient, Astrid. She says she would be more worried if Laura was discharged tomorrow than if Astrid was [...]. She adds that Laura spends so much energy on keeping up appearances to convince everyone that she's doing ok. Sandra answers: ah, so that's why, I only see her when she's out with the others.

P/O, p. 433

Sandra's seemingly innocuous remark about whether Laura was fit for discharge potentially carried consequences for Laura's continuous treatment at the ward. It could be read as a threat to Laura's future stay, a threat picked up by Marianne, Laura's contact person. In order to make a case for why Laura should stay, Marianne invokes the discourse of "really ill". If Laura can be constructed as "really ill", despite her not visualizing the appropriate symptoms, Marianne may secure her continuous stay. She thus applies a familiar psychiatric construction: the patient as consisting of both "a deep core" and "a surface" (Barrett, 1996). In this constellation, patients are regarded as having a core –the source of genuine emotions, trouble and illness, and a surface zone, allowing for the possibility of a false façade which may deceive the unknowing observer. By constructing Laura this way, Marianne can fend off allegations that Laura is not "really ill" and manage to position her as an ideal patient: one who is indeed very troubled and ill at the "core", but at the same time does not allow herself to display symptoms in a too obvious manner. In this way, Laura is constructed as fitting a familiar and well-liked patient posi-

tion: the responsible, tough and not-clingy patient who nonetheless has a private soft side which she only displays to certain carefully selected individuals.

Marianne further contrasts Laura to another patient, Astrid, about whom there was a general consensus that she misused the ward as a “hideout” (Rhodes, 1995), and was not “really ill” (cf. Ringer & Holen, 2013). The comparison and the construction of a sharp contrast between the two, further functions to support Marianne’s construction of Laura as deserving care. At the same time, it perpetuates the consensus construction of Astrid as someone who should be discharged quickly and does not deserve continuous treatment (and indeed, shortly after the conversation took place, Astrid was told that she would be discharged against her will). To further underpin her case, Marianne changes “footing” (Goffman, 2010) by positioning the resident physician, rather than herself as the author of the statement that Laura genuinely is “really ill” - in terms of qualifying for the diagnosis depression. This allows her to draw on expert opinions in order to argue that Laura should be allowed to stay and needs time to get well. When Marianne draws on these discourses and constructs Laura as “really ill”, she opens up for an understanding from the other professionals engaged in the conversation, who support her account by contributing to the positioning of Laura as “really ill”; and so there can no longer be any doubt that Laura should be allowed to stay at the ward if she pleases. Additionally, Sandra, who initially brought the remark up, finally agrees to this version of Laura by positioning herself and her previous remark as due to her being deceived by Laura’s “tough façade” - and her lack of knowledge of Laura’s “true core” (*“that’s why, I have only seen her out there with the others”*). This way, Laura’s continued treatment at the ward was secured for a while.

The example illustrates some of the tensions and difficulties that the professionals faced when they attempted to meet the individual needs of a patient in the face of demands of efficiency. Had Marianne not been so quick to react and construct Laura as ‘really ill’ and fitting within a familiar template, Laura’s future at the ward would possibly have been insecure. It is difficult to know for sure what Laura thought about this, but based on her contact person’s efforts to convince the other professionals about her need to stay, it is likely to presume that Laura had expressed a wish to stay at the ward and to continue to receive treatment. This demonstrates the cunningness and creativity in “moving among the threads of power” (Rhodes, 1995: 174) that the profes-

sionals had to exercise if they wished to be attentive to the unique wishes of a patient. This movement required defining patients and their actions according to well-established local categories. The example additionally demonstrates the difference between patients in relation to how far their contact persons would be willing to go for them. For Laura, this was rather easy, as the way she generally performed herself allowed for a relative straightforward construction of her as “really ill”. Had she, like Astrid, not managed the proper act of balance between “core” and “façade”, it would perhaps have been significantly more difficult for the contact person to argue for her continuous stay at the ward.

Finally, altogether the examples reveal a more general point about contemporary psychiatric work. When the professionals favored continuity in treatment over efficiency, when they favored meeting a unique need over standardized care, when they attempted to find spontaneous and unexpected ways of interacting with patients, they risked being at odds with management and the dominant ideal of efficiency and standardization. The widely adopted discourses of management and organization valued short and standardized treatment with clear goals and a deadline in site. The rhetoric of efficiency and standardization was highly critical of allowing an individual patient to receive care for a prolonged time just because he or she wished for it. This required a balancing act of the professionals with a constant attention to “making exceptions” - turning the treatment into a sanctuary for some patients, while hurriedly discharging others against their will.

Pathologization, normalization and the ordinary human being

The concept of mental illness and the diagnostic model are fundamental to psychiatric knowledge and practice. Irrespective of profession, the professionals in this study, to varying degrees, all seemed to subscribe to a diagnostic model of the patients’ distress. However, some professionals also reflected on the value of normalizing the patients’ experiences. A psychiatrist stated that once the patients were diagnosed, he saw one of his tasks as that of normalization of their experiences.

Frank: if they have thoughts about the neighbor being annoying (.) because he's playing loud music in the evening and you'd like to hit him (.) but then "I'm schizophrenic, so I'm not allowed, and it's probably a schizophrenic thought, and that's criminal" (.) and then you can tell them "but, you know what, it's really kind of ordinary to get annoyed at others" [...] that's what I mean by having the power to define [normality], because it gives people a huge relief, huge [...] to know that it's actually, um, a normal thought.

Frank, IV, p. 8

The psychiatrist's experience that many of the patients had difficulties distinguishing what is "normal" from what is "abnormal" in their experiences may be related to the construction of mental distress that I have previously (Ringer & Holen, 2013) called "the instability discourse". This discourse defines the patient as having a mentally ill core, which can spread and act unpredictably and take over their whole identity. Consequently, it invited patients into an exercise in self-discipline by self-monitoring and self-scrutinizing, continuously searching for signs of pathology. Thus, many patients made self-pathologization an integral part of their identity. In this context, Frank seems to perceive his role as one who should assist in restoring and rebuilding the patients' "sane sides" and acknowledge that not everything the patients think or feel is pathological. He constructs some experiences, such as being annoyed at a neighbor as "just like the rest of us". Barrett (1996: 270ff) has demonstrated how a fundamental tension between "sameness" and "difference" is integral to contemporary psychiatric practice. Constructions of psychiatric patients oscillate between constructions of the patient as "the same as others" and "fundamentally different from other people". In the settings of this study this tension materialized itself in terms of a dialectic relationship between normalization and pathologization. When the patients self-pathologized, the response of the professional would often be normalization, as illustrated by the psychiatrist's statement. Conversely, when the patients resisted the positioning of them as "ill" and normalized their own experiences, the response of the professional would often be one of pathologization. By moving between these poles, the professionals seemed to construct different versions of the patient's identity. In a strict psychiatric sense, when e.g. a patient diagnosed with schizophrenia claims a status as "not ill" or when she makes sense of her distress by drawing on systems of knowledge other than psychiatric, this may be viewed as evidence of her illness and she can be categorized as "lacking insight" (Hamilton & Roper, 2006). As Hamilton & Rop-

er (2006: 418) note, when patients resist psychiatric explanations and draw on other discourses in defining their distress, the professionals' authority and caring subjectivity is undermined. According to them, when this happens: "the professionals can reverse this power exchange by colonizing individuals' refusal of diagnosis and patienthood, framing this within the psychiatric discourse as a 'lack of insight', whether viewed as a symptom, a neurological deficit or as a defense mechanism" (p. 418).

Hamilton & Roper's observation is valid and applicable to the context of psychiatric knowledge and theory. In the context of the practices of the professionals in this study, their exercises in pathologization and normalization appeared to be much more complex and oblique. They often seemed to strive to remain open to patients' narratives of distress, but ultimately often found it difficult to accept these as legitimate when they diverged too greatly from psychiatric discourses. Therefore, many seemed to manage an intricate balance between the forces of pathologization and normalization, looking for ways to be attuned to patients' self-positioning. The following fragment of a nurse-patient meeting illustrates this tension.

Philip: I've started seeing it in a different way, um, instead of like, for a long time now I've seen myself as schizophrenic, in a way [...] and I'm beginning to understand it in a different way and to view it in a different way, and after [I've started seeing it differently] there have been some changes (yeah) both with the voices and um with the stuff I'm experiencing

Petra (nurse): So what, in a positive way?

Philip: Mm

Petra: Yeah?

Philip: Um, I'm seeing myself, understanding it that way, that it's not like really a disease, but something that's kind of a very natural experience, in a way (yeah) and yeah, that that's what it is and that's what comes with it and stuff (mm), um, you could say

Petra: But you, I mean you do see that a lot, that the way you experience the illness, the way you experience it in relation to yourself, is very important for the experience, isn't it? (yeah) [...]. There are a lot of people with schizophrenia, people who have the illness schizophrenia, who, I've met quite a lot of people by now, haven't I, um with this illness. And some people say and

define themselves like: “I’m schizophrenic”. And then there are others who say: “well, I’m Philip and I am myself and then I have this illness with me, which is called schizophrenia” (yeah) but, then you’re not defined by the illness, do you see what I mean?

Philip: Yeah, because I think it’s so indefinable (yeah) also in relation to kind of, um (.) well, um, I think what it says in the books is so limited compared to what you experience, [...]. And that’s it really, um, I see it a lot more spiritually (yeah) than that it’s just something that should necessarily be removed, or whatever.

Petra: [...] It’s also very individual. And there are actually a lot of people who say that when you have voices, or it could be someone who sees something, like has visual hallucinations, (mm) that it actually has a connection with the person you are and, um, the life that you’ve had - with some experiences. That it just doesn’t just come out of thin air.

Philip: No, that’s it, um, really

Petra: That there’s a meaning

Philip: Yeah, exactly

P/O, recorded conversation, Petra-Philip, p. 3-4

Philip opens up for a re-negotiation of the fundamental concept of “illness” and whether it appropriately matches his experiences (“it’s not like an outright disease, but something that’s kind of a very natural experience”). His contact person Petra listens to him, without dismissing what he says, and she is sensitive to the general theme of his narrative: that the way a person relates to mental distress is important. Yet, it seems difficult for her to fully hear his plea to not define the voice hearing as an illness, as she cannot avoid resorting to the concept schizophrenia in making sense of what he says.

In an analysis of the talk of members of user organizations, Speed (2006) has noted how users locate themselves in the position of patient, consumer and survivor in different times and contexts. By subtly implying that his distress is not due to an illness, Philip may be said to position himself within the “survivor discourse” – in resisting medical authority by drawing on a spiritual frame. Although Petra does not dismiss his account, she subtly reframes Philip’s alternative narrative to situate it within a more familiar and legitimate

frame. She may be said to offer him a compromise, by making available a position as “consumer” (Speed, 2006) – as supported by the statement “I have schizophrenia”, rather than “I am schizophrenic”. As Speed notes, such a discourse of “consumer” vacillates between acceptance and rejection of the medical model - it moves away from the passive “patient role”, but still complies with medical hegemony. In positioning Philip in this way and discursively separating “the illness” from him, Petra allows for some equivocality that a strict medical discourse would have closed down. At the same time it allows her to maintain commitment to her medical training and psychiatric knowledge. In this way she makes available a subject position for Philip which is intended to avoid undermining his account, but still constructs him as having an illness. For Philip, such a position of “having schizophrenia” allows for a wider scope of action and agency than “being schizophrenic”; however at the same time, it is a different position than he originally claimed for himself, and perhaps one he is not fully comfortable with it. Towards the end of the fragment, however, Petra seizes to talk about his distress as being an illness, focusing instead on hearing voices and having visual hallucinations. This way they seem to reach a type of compromise, agreeing that there is meaning in hearing voices.

The fragment illustrates one of the core tensions that seemed to face the psychiatric professionals when they wished to remain open to patients’ perspectives on distress, when these diverged from psychiatric understandings. Petra on the one hand genuinely seems to strive to take the statements and positioning constructed by Philip seriously. On the other hand, it is difficult for her to ultimately accept other ways of constructing unusual experiences and voice-hearing than as pathology - and remain committed to her position as psychiatric professional. Her training, professional experience and membership in the professional world of psychiatry have likely not made other interpretational frames of the patients’ distress available - because, as Hamilton & Roper (2006) note, even if many patients challenge psychiatric knowledge regimes, the patients often “cannot be heard if [they] disagree” (420). In trying to accommodate Philip’s stories, Petra therefore has to practice a difficult balancing act between the subjugated discourses that Philip draws on and the powerful psychiatric illness-discourse which threatens to render his account illegitimate.

Precisely because the illness discourses threaten to render other accounts of the patients' distress illegitimate, it may be argued that involving patients' perspectives in this regard was more fundamentally difficult for the professionals than involving their perspectives within the other domains discussed. While the balancing act performed by professionals in positioning as "personal" and meeting a unique need could to some extent be managed by "making exceptions" or doing small adjustments without fundamentally subverting dominant discourses - to accept a patient's unconventional definition of distress as legitimate required a considerably more radical approach to involvement. Because psychiatric definitions of mental illness (and the assumption that the truth about these lies in the sphere of professional knowledge) are deeply inscribed in the very groundwork of psychiatry, involving patients' alternative definitions appeared to verge on the inconceivable. Engaging seriously with spiritual and critical claims such as those of Philip would thus imply a clash with the very historical and institutional self-definitions of psychiatry. In this sense it appeared as if the sphere of definitions of mental illness often provided the boundaries for possible negotiations of user involvement and inclusion of patients' perspectives.

The fundamental difficulty facing the professionals in this endeavor was reflected in yet another case: that of the patient Eliana and her case manager Joanna. Eliana had long been considered a "difficult patient" who had had contact with the mental health services for thirteen years with more than thirty compulsory admissions. The last year and a half, however, Eliana had fully avoided hospitalization. Eliana partly attributed this to her relationship to Joanna. She said: "If it wasn't for Joanna, I'd be dead". She explained that Joanna was one of her first psychiatric contacts who did not "treat her as a mentally ill person". In an interview, the case manager Joanna said that it took two years to gain Eliana's confidence. She explained how she had made sense of some of Eliana's problems:

Joanna: Eliana has this, it's called dissociative thinking [...] She can walk around here in the city and have some ideas about having gone to visit her father who is fatally ill in a hospital in another city (.) all the while as she's been seen around here [by her contact persons]. And the social psychiatric team and [another treatment] team, they would sometimes tell her 'but you're lying, we saw you around here, didn't we' [...] but it's surely no use telling her that it's a lie [...] It's a mental (.) illness which makes her think the way she does, isn't it? [...] Somewhere there is a grain of truth in some of those sto-

ries (.) and it's important to let her keep the stories [...]. With time she doesn't feel the need to tell me those quirky stories about what she has done. She's spent really, really a lot of time telling me these stories, about who she was and what she knew and what she was able to do, and of course, she needs to tell me that she's a person with resources who(.) is able to do a lot of things and so on, doesn't she? (A:mm)(.) That her stories perhaps don't have an exact basis in reality, that's not what's important (.) it was important for her to be able to tell me what she was also capable of.

Joanna, IV, p. 10

As the extract indicates, rather than assessing the level of direct truth in Eliana's stories, Joanna had focused on the speech act and metaphorical meaning. She related the stories to the identity work that Eliana undertook in the interaction - pointing out that it was apparently important for Eliana to present herself in certain ways. In doing this, Joanna seems to take a step towards abandoning what Harper (2004) has referred to as "the constraints of the modernist paradigm" of psychiatric thought. According to Harper, psychiatry is built on an assumption that the clinician has unmediated access to "reality" and should distinguish between "correct" inferences of reality and "faulty" ones. "Faulty" assumptions may be constructed as delusions, which are irrational and meaningless. Accordingly, an important task expected from mental health professionals is to judge the level of truth in patients' beliefs and to re-adjust their faulty world views (Palmer, 2000). By concentrating on metaphorical aspects of Eliana's stories - as serving a function within an interaction - Joanna subtly renegotiates the expectation to judge Eliana's accounts against a rationalist criterion of absolute truth. At the same time, she does not fully breach the expectation to identify pathology. She makes sense of Eliana's stories by putting them in a cognitivist framework - constructing Eliana's stories as consequences of dissociative thinking, and as resulting from a mental illness. Thus, in her endeavors to make sense of the stories, she simultaneously draws on and takes a step towards destabilizing psychiatric knowledge regimes. However, as Joanna explained, a recent difficulty had presented itself which further complicated her balancing act: the last time Eliana was hospitalized she received a diagnosis of schizophrenia. In a situated interview, Joanna reflected upon the new diagnosis:

Joanna says Eliana has the diagnoses borderline and anorexia. She adds that Eliana actually also received a diagnosis of schizophrenia the last time she was hospitalized, but that she, as Eliana's case manager, totally disagrees with

this diagnosis. Because, she explains, when Eliana's lying, it's because she really believes what she's saying. Eliana's very ill, Joanna says, but she's not delusional, "so we quite disagree about the diagnosis"

P/O, p. 91

Joanna is aware of the potent cultural, historical and psychiatric imperative to regard symptoms of schizophrenia, such as delusions, as disconnected from their social context. Without a diagnosis of schizophrenia, the stories can be attended to as "Eliana's quirky stories", permitting some room for explorative interpretation. However, if Eliana's distress is defined as "schizophrenia", Joanna will most likely have to attend to Eliana's stories as *delusions*, as standardized, objectified symptoms without essential meaning. Barrett (1996) has demonstrated how schizophrenia in contemporary psychiatric research and practice is produced as "beyond the possibility of comprehension". He relates this to the legacy and influence on contemporary psychiatric thought of the nineteenth century psychiatrist and philosopher Karl Jaspers. Jaspers asserted that there was a fundamental distinction between psychiatric disorders which could be empathically understood within their social context, and those that were beyond empathic understanding – and thus could only be understood in terms of causal cerebral processes. For Jaspers, *ununderstandability* – the inability to be understood empathically and meaningfully – was the primary feature of schizophrenia, fundamentally separating it from "less severe" disorders. Barrett (1996:222) argues that Jaspers's view of schizophrenia still has significant influence on contemporary psychiatric thought, placing schizophrenia in the sphere of the ununderstandable – as that which cannot be attributed meaning. In this light, the schizophrenia diagnosis is the ultimate threat to Joanna's interpretations of Eliana's stories as carrying metaphorical sense. If the stories are approached as delusions, they will become ununderstandable. Eliana will have to be "corrected" and "reality-checked" – which implies that she has to be told that they are not true and that she is delusional. This would substantially complicate Joanna's wish to "allow Eliana to have her stories". If Joanna accedes to the categorization of Eliana as schizophrenic, she therefore cannot credibly maintain that Eliana's stories have a meaning and are metaphorically relevant. In order for her to argue that Eliana's stories are legitimate and should not be dismissed, Joanna thus has to maintain that they are not delusional symptoms of schizophrenia. When Joanna disagrees with the doctors on the diagnosis, she is therefore essentially struggling to not un-

dermine Eliana's account – and to not situate them within the domain of un-understandable symptoms of schizophrenia.

Together, the examples illustrate the difficult balance involved when the professionals attempted to involve patients' perspectives on their distress under the risk of a continuous undermining of these by psychiatric discourses. Listening to patients' stories about distress without dismissing them involved hard labor, sometimes verging on the impossible. As noticed, the challenges encountered in these endeavors were arguably more fundamental than when it came to listening to individual needs concerning treatment. Although the professionals strived to remain attentive to the narratives of distress expressed by patients, the dominant psychiatric discourses which also informed their work often rendered the narratives of patients illegitimate. Involving patients' perspectives on distress would therefore have to imply a questioning stance towards the very core of psychiatric work - the concept of mental illness and psychiatric knowledge about it. In relation to definitions and negotiations of mental distress, therefore, the power balance in the patient-professionals relationship inevitably became visible. Perhaps for this reason, many professionals in this study who were case managers or primary contact persons (and hence had the most frequent contact with patients) said they often refrained from "talking about illness", focusing instead on topics from the patients everyday life.

Inasmuch as patients' perspectives could be involved in terms of their everyday life, in terms of their unique needs and in terms of the professionals being "personal" – when it came to the patients' experiences and definitions of distress, it seemed to become possible for professionals to involve patients' perspectives only insofar as they supported the dominant discourses of the institution, at least to some extent. In such a context, one may rightfully question whether initiatives of user involvement, especially those aimed at openness towards patients' perspectives on distress, may have any impact at all on the institution, if they do not reflect on and question the basic assumptions guarding psychiatric work.

Concluding remarks

I began the article by asking why user involvement seemingly does not occur to the extent policy makers, patients and many professionals would like it to. Rather than providing definitive answers, the article has opened up for some ways to understand the day-to-day work of professionals and the possibilities and constraints for their practices of user involvement. In many respects the data presented here reproduce the critique of theoretical accounts on the constraints to user involvement referred to in the introduction. However, the article also goes beyond those critiques by demonstrating in fine detail the contradictory discourses inherent in psychiatric practice that the professionals were faced with when they tried to involve patients. As Rhodes (1995:6) has noted, mental health professionals are enmeshed “in a space in which they [are] both watchers and watched, disciplining and disciplined”. In this way the professionals, just as the patients, were made subjects of discipline and had to navigate in a contradictory field. On the one hand the professionals’ work was inscribed in ethical ideals about equality and partnership; on the other they occupied a position of authority with the mandate to use coercion. Maintaining commitment to the discursive norms that defined their position while trying to listen to patients meant the daily work of the professionals required a complex balancing act. When they attempted to involve patients’ perspectives, it appeared as if many tensions arose: the expectations of patients who had learned to position them as experts, the demands of management and administration which required efficiency and standardization, the discourses of expert knowledge - and particularly the construction of mental illness as an unquestionable psychiatric fact. Many professionals in this study said they were exhausted and experienced “care fatigue”. Such an experience becomes understandable in light of the contradictions that they faced every day.

At the same time the professionals did not succumb passively to their entanglement in a system of contradictory demands. They found ways to resist, through strategy, subversion, reflexivity and renegotiation. Their resistance to the knowledge of psychiatry and the disciplining space of the settings was often subtle and oblique. It did not emerge as a unified opposition against a specific oppressive power - but rather developed as an angle to the expected definitions of situations (Rhodes, 1995: 174). It was in the context of such resistance - when the professionals balanced, renegotiated or questioned taken for granted assumptions - that steps towards involving an individual patient’s perspective could be taken. Thus advances towards service user in-

volvement could occur in some contexts, especially when the professionals exercised “making exceptions” or did something different. This point is supported by studies on recovery from mental distress. For example in a study on users’ perspectives on the components of a helping and therapeutic relationship, Denhov and Topor note that the professionals who were perceived by the users as helpful: “have done something more than the user has learned to expect from the professional role. Often it is a case of minor, everyday actions where their importance lies in their ‘extraness’.” (2012: 422). In this study, the “extraness” emerged as subtle “recodifications of power relations” (Foucault, 1980:123) which made it possible for the professionals to, at least for an instance, open up to patients’ perspectives. This point is interesting in relation to the managerialist assumption that user involvement may be secured if professionals just follow standards and legislature, which have user involvement inscribed in them. Such a “top-down” model of user involvement assumes that if professionals just follow “standard procedures”, such as asking patients specific questions and showing them their treatment plan, patients and their perspectives may automatically become more involved in the treatment. In contrast to this idea, the analysis has indicated that it is precisely when “standard procedures”, norms and taken for granted assumptions are re-negotiated, however subtly, that some degree of user involvement may occur.

Finally, the article indicates that if the democratic potential of user involvement is to be exploited, then user involvement ought to be understood as a questioning stance or even resistance to the current power-knowledge structures. It appeared that such a stance was difficult to sustain for the professionals in the long run, particularly when it came to definitional rights over the patients’ mental distress. Generally the professionals’ attempts to involve patients’ perspectives often emerged as individualized solutions which for the most part did not result in any great changes in institutional norms and rationales. Many professionals practiced involvement by listening to individual patients, by focusing on topics from their everyday life, by striving to remain sensitive to their needs and by attempting to not dismiss patients’ experiences of their distress. However, these actions were not always considered relevant in the dominant discourse on treatment and professionalism, which often stressed expert knowledge and technical expertise as important. In such a context, the attempts to involve patients were sometimes not recognized or attributed much importance.

In the present context, it would appear that a more conservative or consumerist degree of user involvement may be implemented – entailing seeing individual patients as people with wishes important for “getting the product right”. However, one may question the extent to which user involvement may reach a genuinely democratic degree, involving liberation, de-stigmatization and a change of definitional rights on mental distress. For such a degree of user involvement to take place, it would seem that mental health professionals would have to be supported much more in their endeavors to involve patients’ perspectives - by a system of psychiatric knowledge which allows for more diversity and multiplicity in definitions of mental distress and patienthood.

Chapter 7: Conclusion

This thesis is about patient identities, discourses and user involvement in contemporary psychiatry. The thesis has examined how these are constituted and ascribed meaning within the institutional context of two mental health settings. I have used an ethnographic research methodology to study the encounters between patients and professionals, and how meaning is constructed, produced and reconstructed in meetings between them. I have further linked these constructions to their social context, the organization, the knowledge and the practices of contemporary psychiatry. In this section I will compile the results of the articles and discuss them together, as well as their implications for clinical practice and research. However, before I move on to a discussion of the thesis' main empirical results, I will briefly consider the contribution of the theoretical and methodological approach I have applied.

From language and values to discourses, norms, positions and subjectivity

The purpose of this thesis has been to examine psychiatric institutions, their practices and assumptions, how they define what it is to be a “patient” and a “professional”, and how they define what it means to experience mental distress. The original description formulated in the PhD announcement stated that the PhD project should: “shed light on and analyze the interaction between language, values and user involvement in a psychiatric context”. It stated the study should focus on:

“...how patients are talked *about*, *to* and *with* in the mental health services” and “what does this mean for involvement in practice, including the possibility to meet the patient as a person with resources and the potential to recover”? [my translation] (Psykiatrien Region Sjælland og Forskerskolen i Livslang Læring, 2010)

The problems I have addressed in this thesis were formulated from within a Foucauldian framework, since this perspective offered insights into language as not only reflecting the world, but as actively creating persuasive versions of

it. This perspective has made it possible to situate the communication (“how it is talked about, to, and with patients”) within a broader institutional and cultural framework. It has helped us explore how the day-to-day language in psychiatric practice is never detached from its social contexts, but deeply ingrained in them. The perspective has invited us to see how the interactions between professionals and patients always draw on broader discourses – discourses about illness and health, care and empathy, normality and deviance, rationality and irrationality, expert knowledge and subjugated knowledges - in the production of subjectivity and personhood. In this way the perspective has allowed us to de-individualize the notion of “values” formulated in the original study description - and to demonstrate instead how these emerge as discursive norms, intimately tied to a specific institutional and cultural context.

Foucault’s theories are developed from a history of ideas approach which analyzes historical documents, rather than dealing directly with the dynamic processes of everyday life and social interaction. There is a risk that an uncritical use of Foucauldian perspectives may reduce all social processes to large, unspecified patterns of domination (Barrett, 1996:104). I have strived to avoid this danger by incorporating discursive psychological theory - and thus by studying individuals as reflexive subjects who also resist dominant discourses and allow for the emergence of alternative subject positions. With a focus on subtle processes of positioning between patients and professionals, it has been possible to move closer to them as experiencing persons, not just as pawns in an abstract system of domination. This “double vision” (Haraway, 1988:589) - encompassing both broader discourses and particular “local” reactions to them - has made it possible to explore how power operates unnoticeably in taken for granted assumptions; but also how the very same taken for granted assumptions are also questioned and reflected upon in practice.

These points could further be specified because the study is based on an ethnographic methodology, which has allowed us to explore the assumptions and systems of thought drawn on in everyday life. With a focus on everyday interactions and participant observation, it has been possible to explore the inconspicuous aspects of psychiatric practice. Had I only conducted interviews we would have been able to explore how professionals and patients talk about their mutual actions and relationships, but not how they actually practice them in everyday life. On the other hand, had participant observation

been the sole method of data production, we might have missed the important points that some of the discourses that patients may draw on in other contexts become silenced in interactions with professionals - and that some of the professionals' efforts to involve patients cannot always be carried out in practice. The approach has thus allowed us to take into account that patients and professionals have experiences which are more far-reaching than only emergent in the observed situations.

We will now turn to the empirical conclusions of the thesis. Throughout the next section I will relate the conclusions to the existing body of research on psychiatric patients, mental health professionals and user involvement, which was reviewed in Chapter 2. This is done in order to link the results to other studies and to discuss this study's contribution to the existing research.

Patient identities, illness discourses, and user involvement

The research question of the thesis asked: How are identities as psychiatric patients constituted discursively in the contemporary mental health services? What are the implications for patients and for involving their perspectives in the treatment?

The thesis has approached the questions in three articles written from different angles: by analyzing processes of researcher positioning; by analyzing discourses on mental illness and their implications for patients; and, finally, by analyzing practices of user involvement among psychiatric professionals. Altogether, the thesis points towards the presence of specific discursive norms with implications for how patients could act in order to be perceived as persons with views which should be involved in the treatment. In contrast to the official rules of the settings which were clearly written down, the norms worked as implicit assumptions, which were rarely made explicit. Furthermore, they were not clear-cut and straightforward, but functioned in different ways in different contexts. Being recognized as legitimate thus relied on the patients performing a complex balancing act, as there was not one straightforward answer as to how to they should act or position themselves as patients. Just as the discourses provided norms that shaped how patients and professionals could be defined, they also provided boundaries for how the

researcher could be understood during the fieldwork. As we saw in the first article, no matter how hard I tried to negotiate different identity-claims, the pre-existing discourses on illness and sanity and on patients and professionals became a prism through which the researcher's identity was appraised. Similarly, it was difficult for the researcher to avoid reproducing some of the objectifying practices in the institution, by asking questions to the patients and occupying a position as someone whose role was to examine other people. The point that my own researcher positions became inextricably entangled in the discourses indicates that they were broad and connected to institutional processes, rather than merely manifestations of idiosyncratic situations or individual characteristics.

The discursive norms seemed to be particularly complex in relation to assumptions about the patients' distress. We saw how three discourses on mental distress foregrounded particular ways of being ill, rendering inauthentic or problematic other expressions of mental distress. The *instability discourse* constructed the patients' distress as due to an inherent instability, and portrayed the patients as fragile containers for the instability. It asked of patients and professionals to think of patients as passive objects fundamentally controlled by an unstable "core" - inclined to erupt at any time. It invited patients to self-monitor, continuously searching for signs of mental pathology. A second way of constructing mental distress was identified as the *discourse of "really ill"*. It constructed patients as consisting of a "core" and a "façade" and thus it added a layer of volition and intentionality to the patient, opening up for the possibility of patients "simulating" the illness. It produced a sharp contrast between illness that was "real", and illness that was "not real" or "less real"; requiring from patients that they learn to visualize their distress in a recognizable way to be allowed to continuously receive care. The third identified way of thinking and talking about patients was defined as the *"lack of insight" discourse*. It constructed psychiatric knowledge about patients' distress as an unquestionable truth, and invited patients into a position from which they should acknowledge the inadequacy of their own knowledge. The "lack of insight" discourse constructed narratives on mental distress which diverged from psychiatric as less legitimate and taught patients to silence or transform such narratives if they wished to have a say in their treatment.

The analyses thus indicate that patients were required to develop a finely-tuned sense for the discourses and to make strategic considerations as to how to appear and visualize their distress. This finding is consistent with some of

the studies discussed in the literature review (e.g. Johansson, 2010; Topor & Di Girolamo, 2010), which similarly showed that psychiatric patients develop conscious, even rational strategies to navigate in the maze of the mental health services. However, while Topor & Di Girolamo (2010) related this point to patients' adjustments to individual professionals, and Johansson (2010) related it to patients' own identity work in order to become "authentic" subjects, this study has shown that the strategies may also be understood as ways for patients to learn to comply with discursive norms in order to have a say and be involved in their treatment. Patients who insisted on different expressions of distress than what was institutionally recognizable were often rendered problematic or perceived as un-cooperative. Furthermore, some studies in the review found that for many users of psychiatry, the position of "psychiatric patient" and the idea of "mental illness" is endowed with ambivalence (e.g. Tucker, 2009). This study has expanded our understanding of the ambivalence by pointing to the complex ways in which the concept of mental illness is negotiated in the mental health services – and the contradictory and ambivalent patient positions they produce. For instance, for patients like Anna, the illness discourses became both a mode of explanation and a mode of self-pathologization - and for patients like Susanna and Hanna, their contact to the psychiatric services simultaneously provided legitimacy and a feeling of distrustful judgment.

Regarding the position of professionals, the results of this thesis are consistent with the reviewed studies that show that mental health professionals are subject to a large workload and time pressure, and that their work is more about managing flux and time pressure than stability (e.g. Michelle Cleary, 2004; Donnison et al., 2009; Hummelvoll & Severinsson, 2001). However, while some of these studies emphasize that time pressures create tensions between the ideal and practice, this thesis has shown that the fundamental tensions and contradictions in mental health professionals' practices need rather to be understood in terms of deeply ingrained historical and institutional discourses. These will likely not recede (although their acutely stressful impact on psychiatric professionals might) even if workload is decreased. The thesis has indicated that the professionals, just like the patients had to navigate in a constant contradictory field. The position of mental health professionals was defined from a range of different expectations and demands: they were expected to act like experts, who should use their professional judgments to spot psychopathology and to know what was best for the patient; they had to adapt to the demands of an extensive standardization of their practice; they

had to think in terms of efficiency and technical solutions; they had the mandate to use coercion; at the same time their practice was inscribed in ethical ideals about equality, partnership and listening to patients.

The contradictory quality of these expectations may have roots in the fundamental tension discussed in the chapter on the history of psychiatry (Chapter 3), namely that psychiatry has traditionally rested on two contradictory forces: a moral discourse which constructs patients as experiencing subjects and a technical discourse which constructs patients as objects. The “patient as object” construction asks of the professionals to be unquestionable experts, who should expose patients to various technical treatments (and in recent times to finish the treatment quickly and efficiently). The “patient as subject” discourse treats the patient as a person with human needs, who should be listened to and cared for. In this way, historical processes seem to shape and inform contemporary psychiatric practice. The daily work of professionals therefore required walking a tight-rope: remaining committed to a position of technical expertise while attempting to listen to patients.

This point is interesting in relation to the tendency we saw in studies to consider a great obstacle for involvement to be professionals' negative attitude towards patients' capabilities to being involved (e.g. Anthony & Crawford, 2000; Petersen et al., 2012; Summers, 2003). This study has complicated this picture substantially. Firstly, the analyses have shown that ideas about psychiatric patients “lacking capability” to be meaningfully involved do not merely emerge as individual professionals' reflexivity, but are tied to the historical and institutional context with specific preconceptions about mental illness and the identities of psychiatric patients. Secondly, we have seen that even when professionals do strive to involve patients and do believe that they can be involved (and most professionals indeed say they do), the very same discursive constructions often work as constraints and contradictions. In such a context, when it became possible for a professional to take the perspective of a patient seriously, most often this could only emerge as an individualized solution, relying on an exercise in “making exceptions”.

However, when patients positioned the sources of their distress within non-psychiatric systems of belief, the extent to which their ideas could be listened to and engaged with seriously seemed to be limited. In this way, it appeared as if the very definitions of mental illness sometimes provided the boundaries for involvement. Because core psychiatric discourses constructed non-

psychiatric understandings of mental distress as the patient “lacking insight”, these understandings often had to be dismissed. On the one hand, then, the professionals were expected to listen and take the perspectives of the patients seriously, on the other they were sometimes expected to reject these as expressions of underlying pathology.

Even if professionals attempted to involve the patients’ understandings of their distress, this was made complicated by the fact that these had often been molded and transformed in order to suit the expectations and definitions of the institution. This unsettles the notion of a static “patient perspective” (which much research and policy of involvement is built on), because the patients “perspectives” on their distress were often shaped and elaborated in accordance with the dominant discourses in mental health care.

Estroff’s (1985) study on psychiatric clients in an American community (cf. Chapter 2) demonstrated that often what is the most detrimental to psychiatric patients is not the “symptoms” or their distress per se, but the stigmatization and the processes of self-identification with the illness that they experience. In other words, what appears to define whether a person is able to move towards recovery is not necessarily the gravity of his or her initial distress, but the reactions towards them and the definitions of them in society and in the mental health services. Therefore, the ways the mental health services define mental distress and approach the patients’ problems is not without consequences. Whereas most patients of this study needed little convincing that their distress was caused by a mental illness, and some certainly already had made such claims prior to their entry to the mental health services, others emphatically resisted this idea. With patients such as Frederik, Johan, Noel and Eliana, it seems that it would only be possible to engage seriously with their perspectives if a quest for defining “absolute truths” about their distress is abandoned - and if more diverse and pluralistic definitions of emotional distress are embraced. If the right to define patients’ distress lies unequivocally within the domain of the professionals, the perspectives of patients who draw on other systems of knowledge will have to be excluded. When this happens, it is not only the alternative understanding that is dismissed, but the identity of the person who represents them. As Arthur Frank (1995) has noted:

“People whose reality is denied can remain recipients of treatments and services, but they cannot be participants in empathic relations of care” (Frank, 1995: 109).

In this way, it seemed that the idea of involving patients and their perspectives is greatly restrained by the relatively rigid norms on mental distress, patienthood and truth in the institutions – norms that the patients were expected to, at least to some extent, make their own. This calls into question the extent to which patients could actually influence their treatment, since gaining such influence in the first place meant that they often had to actively adopt the prevailing assumptions of the institution, and sometimes to dismiss their own, in order to be heard at all. In such a context, perhaps a more consumerist or conservative degree of user involvement may take place - relying on professionals' striving to make minor adjustments to attempt to accommodate a patient's individual wishes regarding treatment. However, it appears less likely that the democratic and radical potential of user involvement can be exploited - entailing patients participating and instigating lasting and fundamental changes at all levels of the organization.

User involvement – moving beyond the constraints

Broadly speaking, the results of the thesis question the extent to which initiatives aimed at user involvement will have a lasting impact on psychiatric practice, if they do not take into account the effects of psychiatric knowledge. We have seen how definitions of mental illness are negotiated between people in the discursive climate of the mental health services. Thus, the idea that mental health services operate with objective descriptions of patients' distress, presumed to exist independently of contexts, power and uncritically taken for granted assumptions, should be revisited. Similarly, it appears essential that any wish to implement user involvement should take into consideration that mental health centers are institutions in which psychiatric knowledge develops into complex local constructions which define the types of patient identities that may become legitimate and those that may not. As the thesis has shown, becoming a psychiatric patient is a very complex and demanding endeavor. It is about developing a finely-tuned sense for the assumptions, norms and expectations which are present in the institution, to read these correctly and to position oneself in accordance with them. The analyses thus indicate that the managerialist ideal to think of psychiatric patients as free and equal consumers who can choose freely on a market of mental health care is misleading (Holen, 2011).

However, far from being oblivious to the wishes of patients, the analyses show that many professionals strive to remain open to what patients say, but that this is made complex by the relatively strong norms in the institution. One may thus say that to seriously engage in user involvement, the professionals need to be supported in their endeavors to involve patients' perspectives by a psychiatric system which does not only rely on unquestionable psychiatric truths. Allowing for the democratic potential in user involvement to unfold would mean acknowledging that the stories told by powerful institutional discourses are but one possible narrative. This would imply opening up and engaging seriously with the multiplicity and diversity of patients' perspectives, also when these diverge from traditional psychiatric understandings.

Unfortunately, rather than developing in the direction of embracing multiplicity and diversity, the contemporary trend in the mental health services is to move towards a greater standardization and streamlining of services. Such a movement may further narrow the scope of possibilities for negotiation for both patients and professionals. *For patients*, the standards become tangible materializations of professional definitions, which risk further undermining alternative narratives. When the patients' diagnosis fully determines the form, content and length of treatment, as is the case with the increasing development of "treatment packages" (cf. Chapter 1), the space for accepting individual patients' understandings is further narrowed. *For professionals*, the standards and benchmarking risk undermining their relative autonomy and thus minimizing their window of opportunities for practicing user involvement. The increased standardization is in itself difficult to reconcile with the wish to create individual solutions based on the patients' wishes. Additionally, the standards are sometimes outright contradictory, as in the examples when patients wish to stay hospitalized, and the standards demand efficiency and quick discharges. In such instances the professionals have to choose between listening to patients and complying with an external demand about the shortest possible hospitalization (Holen, 2011). Additionally, as we have seen, standardization may make the professionals wary of making their own professional decisions - which they still have to do, because mental health practice can never actually be fully standardized (ibid.).

In this way, concerns may be raised as to whether the current consumerist model of user involvement will just result in a "box-ticking" exercise (Beresford, 2002:102) with an influence limited to tokenism. If the impact of

initiatives aimed at promoting user involvement is to be more than tokenistic, it appears crucial that they involve a critical reflection on how psychiatric knowledge and practice are organized. It seems essential that mental health professionals and the management give consideration to the theories, philosophies and approaches that underpin the current models they are working within. What could be addressed are disputable concepts such as “lack of insight”, which by implication may dismiss any other explanation than the one put forward by professionals. Similarly, the ideal to discharge patients quickly and efficiently may conflict with the wish to listen to them and allow them to narrate lengthy stories on their experiences.

Today, there are a number of new ways to think of mental health and distress, the work of mental health professionals and user involvement, which embrace more diverse and multiple definitions. A notable example is the work of the Hearing Voices Network, which has developed many ideas and practical guidelines on how to approach and understand voice-hearing in a less reductionist way (cf. chapter 1) - and also provides training for mental health professionals. Other examples are the critical empirical and theoretical psychiatric research which I have drawn on in this thesis (e.g. Bracken & Thomas, 2001; Cromby et al., 2013; D. B. Double, 2006; Knight, 2009; Rapley et al., 2011; Read, Mosher, Bentall, & (Ed.), 2005). This literature points to the poor scientific validity and reliability of psychiatric categories such as schizophrenia, and encourages psychiatry to develop new ways to approach patients’ distress without dismissing their views and understandings. Some accounts suggest abandoning the current illness categories such as diagnoses, instead making patients’ *complaints* the base of psychiatry (Bentall, 2003: 141). From this perspective, patients’ complaints are not seen as symptoms of an underlying illness, but instead as a center of attention in their own right. Yet other accounts encourage psychiatry to move away from a direct realist epistemology that focuses on the veracity of patients’ alternative stories of distress - as this may result in an invalidation of them. Instead they encourage psychiatry to take a more constructionist stand, acknowledging that the stories have important metaphorical meanings (Harper, 2004; Hornstein, 2009b). From this perspective engaging seriously with patients’ alternative views on distress does not necessarily imply that the clinician accepts at face value stories that may seem bizarre or in the domain of the *ununderstandable*. Such an interpretation would again rely on an objectivist notion of truth, substituting one truth with another. Rather, it would imply taking an “agnostic position”, focusing on the

content and context of the stories, especially their historical and biographical meaning (Harper, 2004).

Finally, it appears essential to involve patients more in the treatment, not only by developing programs for peer-support (which is an aspiring practice in Denmark, (cf. Hansson, in prep)), but also by inviting the people who are using mental health services to actively develop models for user involvement. This may bring opportunities to advance new approaches and perspectives on user involvement that are genuinely emancipatory for the people who use mental health services (Stickley, 2006). If this does not happen, newer initiatives aimed at involving patients may run the risk of reproducing old patterns. It is for instance noteworthy that one of the settings studied in this thesis based the treatment on Open Dialogue, which in principle is built on the idea of polyphony, multiple definitions of distress and a democratic approach to involvement. As we saw in chapter five, however, it appeared that the potentially more radical elements of Open Dialogue had been downplayed in the work of the unit, as they could not be meaningfully implemented in the context. It would seem that being situated in a psychiatric system where polyphony becomes narrowed and standardized makes it difficult to carry the more far-reaching implications of Open Dialogue into practice.

The very term “user involvement” is built on an understanding of the user being *involved* into something which is already almost a ready product (Bengtsson, 1997). From the very beginning, then, the term appears somewhat ambiguous and seems to leave little space for changes and reforms with a lasting impact. Perhaps User-led Psychiatry, as the project in Region Zealand is named, is a more promising terminology for democratization on more levels of the organization – also in planning and policy-making. However, it has been pointed out that insofar as patients are allowed access to planning and development of mental health services, their role is often one of “consultants” (Pilgrim & Waldron, 1998). Allowing for a widening of the possibilities of user involvement would likely mean opening up for a greater influence of patients on policy than consultancy. This may imply what Swartz (2005:521) has called “unlearning clinical privilege” by allowing patients not only to be involved and to make choices, but to play an active part in re-defining and re-structuring the organization of treatment. In this way, perhaps more multiple and diverse definitions of patienthood, the work of professionals and mental distress would become more readily available for both patients and professionals.

Methodological reflections and implications for research

Quality, validity and transparency

Appraising validity and quality in qualitative research is complex. While some qualitative researchers take a direct realist approach, applying criteria such as inter-rater reliability measures in a similar way to quantitative research (McGrath, 2011), such measures are built on an a correspondence theory of an objective, universal truth which is incompatible with a postmodern research perspective (Kvale, 1995).

If the analysis can never create a one-to-one correspondence with “reality”, how then may the validity and quality of a study be appraised? Malterud (2001) has suggested three criteria for assessing the quality of qualitative research in the field of medicine: relevance, validity and reflexivity - and a set of sub-criteria, such as transferability, transparency about the theoretical perspective and a systematic procedure. An analogous set of criteria has been proposed by Elliot, Fischer & Rennie (1999), who stress as guidelines for assessing quality: disclosure of perspectives and details about the sample, grounding interpretations in examples and providing credibility checks, as well as coherence in presentation and interpretative framework.

What these criteria share is firstly an emphasis on *transparency* as a general criterion for quality, meaning the researcher being explicit and rigorous in describing her methods and perspectives. I have made it a priority to present and argue for my theoretical and methodological perspectives extensively in the theory and methodology sections of the thesis, as well as to situate these in relation to other theoretical and methodological traditions. I have also strived to present rich data extracts to ground my interpretations in the data – and I have searched for counter-examples throughout the text. An important part of presenting a transparent account may be argued to be *reflexivity*, involving a discussion of the subjectivity and effects of the researcher (Malterud, 2001). My situated perspective, inspired by Haraway (1988) has encouraged me to be committed to reflexivity and to acknowledge that the perspective of the researcher is always partial and situated. It has been crucial to account for the effects of the positioned researcher throughout the thesis and I have devoted much space for this in the first article.

The second general criterion shared by the two sets of standards is a commitment to *coherence* and a location of the interpretation both in the data and in the theoretical literature. Kvale (1995) writes of validity in postmodern research as a quality of craftsmanship - conceptualizing validity as involving “defensible knowledge claims” (Kvale, 1995: 26) based on checking, questioning and theoretically interpreting the findings. Throughout the analysis I have cross-checked and questioned my assumptions and continuously grounded these in the theoretical and empirical literature. In this way I have strived to show how my interpretations have not just arisen from my own assumptions, but how these have emerged and developed in constant dialogue with theory and studies on related topics. As we have seen, I have also approached my data from different angles (researcher, patient, professional) with an awareness of the partiality and situatedness of all knowledge.

Finally, Kvale (1995) has made a case for pragmatic validity, suggesting that the validity of qualitative research should partly be judged in terms of its usefulness and application. In this sense, the “truthfulness” of a qualitative study is also about contributing fruitfully to public discussions about values, goals and practices. A valid study is thus a study which produces results that are meaningful for the people it concerns and one that may instigate social change. Validity becomes as much a moral and political issue as an epistemological reflection. My aim with this study has not been to claim that I present a total picture of language in psychiatry or that I “discover how psychiatry *really* is”. Instead, my aim has been to develop an account of the mental health services and the subjects within it from different perspectives, which hopefully opens up for reflexivity and potentially fruitful discussions. To make the study meaningful for the people it concerns it has been important to approach the research question from different angles and to maintain solidarity with the participants in the study and the difficulties they were facing. Additionally, the study has been politically charged from the onset and at risk of fuelling a climate of competition between different districts. To avoid any such connotations, I have chosen to conduct the fieldwork in two psychiatric settings with different structures and functions, and I have strived to analyze commonalities which may be found across the settings. Additionally, it has been crucial to constantly reflect on the possible consequences of the study and the implications of my political, moral and theoretical commitment. I believe that the thesis has succeeded in the endeavor to open up for a discussion of the concept of user involvement and for reflections on how psychiat-

ric knowledge is organized. I have strived to avoid individualizing user involvement by showing how user involvement is constrained by discourses that the individual cannot just disregard. In the end, however, the pragmatic validity of the study and of my theoretical and political framework remains yet to be appraised.

Methodological reflections and critique

I have studied the settings in a specific time and place. During the fieldwork, each setting had either recently undergone, or was in the process of undergoing administrative reorganization or renaming. Some professionals told me that this was an unusually hectic and unsettling time for their work. At the ward, for instance, many professionals felt unequipped to handle the new constraints associated with their transformation from an open to a closed unit (e.g. patients who were more acutely distressed and an increased mandate of authority over them). It is possible, even likely, that some of my points in the analyses reflect this situation. This may perhaps make it more complicated to judge about the transferability of this study to other psychiatric settings. Even so, it appears that a state of change and unsettlement may be the rule, rather than the exception in Danish mental health services. Other mental health ethnographies in Denmark, such as Johansen (2005) and Søndergaard (2009) have similarly noted that as they were writing up their thesis, the settings they were studying were undergoing administrative and structural changes. This is likely not coincidental; it would appear as if the authorities cannot settle for longer on any one model of services, and hence continually keep restructuring the psychiatric system. The scene I am presenting in this thesis therefore inevitably captures an instant, a specific moment in a specific context within the mental health services.

I have attempted to portray dilemmas and contradictions in psychiatric practice throughout the analyses. However, it may be discussed whether in my striving to explore broad patterns which were present in both institutions I have sometimes overlooked specific important local differences between the settings. This is a point which may be raised in relation to any study which focuses on similarities across different contexts, however in this particular study it is also related to questions regarding ethics and anonymity. Because the study's pragmatic validity has been important, and because the study has been politically charged, I have not focused substantially on the differences

between the settings. This would perhaps have involved the danger of some readers interpreting the thesis in terms of one of the settings “being better” at involving patients than the other. Such an interpretation would have been counterproductive for the aim of the thesis, which has rather strived to open up for a reflection of the effects of psychiatric knowledge and practice in general. Nonetheless, it is possible that a greater sensitivity to local context and difference between settings would have contributed with additional fruitful insights.

As noted in chapter one, part of the reason for why the social sciences and psychiatry drifted apart as disciplines was the developments towards social constructionism in sociology. My choice of theory, which draws on constructionist approaches, can therefore be discussed. Taking such a stance inevitably implies that the study becomes critical, for some readers even perhaps daring or radical, in that it attempts to unearth concepts and assumptions taken for granted. There is a danger that the study becomes too distant and produces defensive responses among the people it concerns. This has been a source of continuous reflection and has perhaps complicated my own balancing act among the institutions involved in the study (cf. Chapter 1). Additionally, although I have incorporated psychological theories on how discourses are applied and experienced, there is a limitation in the theoretical perspective which remains difficult to overcome. On the one hand it presents anti-essentialist understandings which regard the person as constituted by discourses, on the other I have discussed for instance the “perspectives” of patients - thereby assuming that people do have experiences, wishes and assumptions that are not only emergent in the interaction. In this way, my analyses are built on tensions between the distributed and personal, the private and public and between agency and structure, which to some extent remain theoretically unresolved. This is related to a more fundamental critique that may be raised in relation to discursive theories in general, in that they face a challenge when trying to account for the sources of personal agency and resistance. Because my aim in this thesis has been to focus on developing an understanding for psychiatric practice and the positioning of patients, it has not been my purpose to get to the bottom of this debate.

A final critical reflection may be raised regarding my choice to disseminate the analysis in the form of articles. Such a format inevitably demands from the researcher that she condenses the text and makes the discussion precise and to-the-point. It may therefore be discussed whether my choice to write

the analysis in the form of articles has resulted in some nuances and “richnesses” in the data receding in favor of more compact descriptions. Indeed, in writing the articles, I have certainly made selections and deselections, often concentrating on one specific extract as illustrative among many possible. Thus, there are clearly many parts of the data, examples and cases that I have not pursued. Rather than aiming at providing a “total picture” of the “cultures” of the settings, I have used the data to explore specific questions that have been related to my overall research interests. In this sense perhaps precision and specificity have at times been given more attention than lengthy descriptions of the empirical material. At the same time, the analytical and interpretative process in a qualitative study inevitably implies reducing complexities and selecting specific cases while excluding others – and here the article format is no different than the monograph. To accommodate this, I have strived for a great degree of transparency by making my selections and the development of analytical categories explicit for the reader (cf. Chapter 5). Although I acknowledge that my analyses perhaps do not encompass the lengthy descriptions of data that a monograph sometimes can provide, I have also found that the format of articles has entailed strengths for the analytical process. In writing the articles and working with the data at different stages it has been possible for me to develop multiple perspectives and readings of the same data. This has been helpful in presenting a nuanced and differentiated account. Additionally, the format of articles asks from the author to remain focused and constantly aware of the overall argument that is being discussed and the relevance of each part of the text. This has helped maintain coherence, preciseness and specificity.

Implications for future research

In the analyses I have focused specifically on fundamental points of tensions between different systems of knowledge in patient-professional meetings. A type of conflict which I have not addressed in any great detail is the tensions between different professional groups in the interdisciplinary team. The reader may therefore be under the impression that the co-operation between team members was always harmonious and smooth. This was certainly not the case. There were many tensions and sometimes outright conflicts between team members with different professional backgrounds. However, since my particular focus in this study has been on meetings between patients and professionals, the collaboration and tensions between different professional

groups has not been given priority. And yet, it is likely that the inter-professional relationships in a team have an impact on how patients are defined. A point for further inquiry could therefore be to look more closely at the processes of positioning among multi-disciplinary professionals and relate this to the study of patient identities and user involvement.

The review showed that most studies on mental health approached psychiatric practices from the perspective of either patients or professionals, where the group which was not centered tended to feature more vaguely. To develop a fuller picture on psychiatric practice and the effects of psychiatric knowledge, in this study it has been important to approach the field from different angles and to center different groups. Furthermore there has been a tendency in research to approach the practices of mental health professionals either largely uncritically or, on the contrary, to see them solely as instruments of power. Especially in relation to mental health professionals, it seems important to understand their practice as one of managing multiple contradictions that have emerged as a result of historical and institutional processes. The study thus invites future research to look at psychiatric practice from a situated, theoretical angle and to take account of all subjects in the field as reflective and purposeful agents.

The study also has implications for qualitative research methodology more generally. The participatory aspect in participant observation is often discussed as a matter of *how much* participation the researcher engages in rather than *how* she engages in the field. Many researchers limit their discussions to placing themselves somewhere on the classic continuum of Spradley (1980) ranging from non-participation to complete participation. The methodological approach in the thesis (esp. Article 1) encourages qualitative researchers to not only discuss their degrees of participation, but also to elaborate on how they participate in the field. Additionally, the thesis has demonstrated that processes of researcher positioning may not only be understood as methodological reflections, but may be analyzed as data in their own right. There may be a tendency in qualitative research to regard reflections on researcher positioning as an isolated topic, which solely serves the function of being transparent about methods. This thesis instead invites qualitative researchers to attempt to transcend the division between methods and research outcomes - and to attend to the dilemmas during fieldwork as an index to the social world of participants.

A study of this type additionally demands further research of similar processes to be made. In this regard it would be especially interesting to develop more sensitivity to local contexts and e.g. explore the implications of architecture, materiality, and the difference between outpatient clinics and inpatient units for the production of psychiatric knowledge and processes of positioning. Similarly, in this study I have focused on the institution of psychiatry and the people within it. I have thus not followed patients into other contexts of their life or to meetings with other welfare institutions. And yet it is plausible that these play a part in how patients may position themselves in relation to the mental health services. A point for further inquiry could therefore be to extend the research area to also explore other parts of life, the importance of different settings and materiality, and to analyze how these interplay with the possible positions that become available in the mental health services.

It is also likely that many of the social processes I have studied are found in other modern institutions that deal with people. The interpretative work of professionals to work on the identity of users, to reframe their lived experiences in terms of institutional expectations, as well as initiatives of resistance against these practices, are surely not unique to psychiatric practice. During this PhD-project I have co-operated closely with Ditte Dalum Christoffersen, a PhD-candidate who studies social processes and learning in Danish schools (Dalum Christoffersen, in prep). The similarities in our observations – in a primary school setting and in the mental health services respectively - have sometimes been remarkable. Similarly, Mari Holen's study (2011) on constitutions of patients in general hospitals contains many points of correspondence with this study, and my co-operation with her, also involving an article in this thesis, has been rewarding.

Finally, the study has implications for psychiatric research broadly defined. Psychiatric research is often based on an implicit assumption that categories of mental illness are atheoretical, ahistorical and objective descriptions of the reality of these people. Along with many other studies from a critical psychiatry perspective, the results of this study encourage psychiatric researchers to reflect on the ideological and historical assumptions that these categorizations are based on – and the effects they have. Similarly, the study has indicated that how mental distress is ascribed meaning is very much dependent on the social context and how an individual patient learns to navigate in the landscape of the mental health services. This invites psychiatric researchers to re-

flect on how different categories and diagnoses emerge and what their implications may be for the people they concern.

Abstract

The thesis “Listening to Patients’: A Study on Illness Discourses, Patient Identities, and User Involvement in Contemporary Psychiatric Practice” is an investigation of patient identities, psychiatric knowledge and the idea of user involvement in mental health institutions. User involvement, or the initiative to involve patients and their perspectives more actively in psychiatric care, has become a major political aim in recent decades. With an inspiration from poststructuralism, the thesis regards the practices of the mental health services as a type of identity work with patients. The thesis thus approaches the question of user involvement by asking: How are identities as psychiatric patients constituted discursively in the contemporary mental health services? What are the implications for involving patients’ perspectives in the treatment?

The thesis employs an ethnographic research methodology to study the encounter between patients and professionals - and how meaning is constructed, produced and reconstructed in the meetings. The methods involve participant observation lasting three months in two psychiatric institutions in Denmark: an outpatient clinic and a closed inpatient ward, as well as individual interviews with 13 patients and 11 interdisciplinary professionals. Theoretically the study is informed by Foucauldian perspectives on discourses, norms and knowledge - as well as psychological discourse theory, particularly positioning theory.

The thesis begins by introducing the study and some of the controversies and debates that surround contemporary psychiatry. *Chapter 2* reviews excerpts of the existing, primarily qualitative, research on psychiatric patients, professionals’ practices and user involvement and discusses the possible contributions of this study. *Chapter 3* briefly presents psychiatry from a historical and contemporary history of ideas perspective and discusses the functions and structure of the modern Danish mental health services. The next chapter, *chapter 4*, discusses the theoretical and methodological perspectives that guide the thesis: the viewpoint of situated knowledges, Foucauldian perspectives on language, discourses and knowledge as well as psychological positioning theory.

In *chapter 5*, information about the study's design, its methods and the concrete settings of the fieldwork are presented, as well as reflections on research ethics and the analytical procedure. The results of the study are disseminated in three articles, which together form the thesis' analysis in *chapter 6*. The first article approaches the research question from a methodological framework; it analyzes processes of researcher positioning during the fieldwork as sources of data and demonstrates how these were indicative of discursive norms active in the field. The second article analyzes discourses on mental illness in the institutions and looks at their implications for patients. The third article explores the professionals' practices of user involvement and the possibilities and constraints for involving patients' perspectives that emerged in the discursive context. Finally, in the thesis' *conclusion*, the results are recapitulated and discussed in relation to the aim of developing a more involving approach in the mental health services.

The analyses indicate that psychiatric patients are invited to adopt the prevailing understandings of the institution if they wish to be involved in the treatment. Three distinct institutionally rooted ways of thinking and talking about patients' emotional distress, couched in terms of mental illness, are mapped out: the instability discourse, the discourse of "really ill" and the "lack of insight" discourse. It is shown that for patients these bring to the foreground particular ways of visualizing and "doing" mental illness, rendering inauthentic or problematic other expressions of distress. Patients are required to develop a finely-tuned and precise sense for the discourses and to make strategic considerations as to how to appear in front of professionals in order to be involved in the treatment. Patients who are not able to decode the discursive norms appropriately risk becoming unintelligible for the professionals, being problematized, or having their views dismissed. At the same time, the thesis indicates that both patients and professionals find ways to resist the discursive norms. It is shown that, just as the patients, the professionals have to navigate in a contradictory field. On the one hand their work is inscribed in ethical ideals about equality and listening to patients, on the other their positions are grounded in technical discourses on expert knowledge. Involving patients' perspectives therefore entails a complex and difficult balancing act for professionals, which often involves a subtle re-negotiation of discursive norms. These subtle negotiations can rarely result in more than individualized solutions, exercises in "making exceptions". Additionally, when it comes to definitions of mental distress, the degree to which patients' explanations and

understandings may be involved in the treatment is limited, when these conflict with mainstream psychiatric definitions.

Just as the discourses provide norms that shape how patients and professionals can be defined, they appeared to also provide boundaries for how the researcher could be understood by the participants during the fieldwork. Throughout the fieldwork, the categories “patient” and “professional”, and the binary pair “pathology” and “normality” worked as a structuring norm in all the researcher’s interactions with participants. These binaries left little space for negotiating places in between and shaped how the participants could interact with the researcher. It is argued that when the researcher’s process of positioning becomes inextricably entangled in the available discursive norms, this indicates that the norms were broader and distinctly rooted in institutional processes, rather than just manifestations of individual participants’ characteristics.

The results are discussed in relation to recent attempts to implement a more inclusive and involving approach in the mental health services. The analyses call into question the extent to which psychiatric patients actually can influence their treatment - since gaining such influence in the first place often means that they have to adopt the prevailing assumptions of the institution, and sometimes to dismiss their own, in order to be heard. Based on the analyses it is suggested that to practice a more democratic degree of user involvement, mental health professionals would need to be supported in their endeavors to involve patients’ perspectives by a system which embraces more diverse definitions of mental distress and patienthood. The discussion also highlights the importance of involving the people who are using the mental health system to a much larger extent in developing models for user involvement. This could perhaps open up for serious engagement with the multiplicity and diversity of patients’ experiences, also when these diverge considerably from traditional psychiatric understandings. The thesis thus opens up a discussion on how psychiatric knowledge is conceptualized and constituted in the practices of the mental health services – and the effects this has on patients and professionals.

Resumé af afhandlingen

Afhandlingen “At lytte til patienter: en undersøgelse af sygdomsdiskurser, patientidentiteter og brugerinddragelse i moderne psykiatrisk praksis” er en undersøgelse af patientidentiteter, psykiatrisk viden og ideer og brugerinddragelse i psykiatrien. Brugerinddragelse, eller ønsket om at involvere patienter og deres perspektiver mere aktivt i behandlingen, er blevet en vigtig politisk målsætning de sidste årtier. I tråd med poststrukturalistiske perspektiver ser denne afhandling psykiatriens praksisser og sprogbrug som et slags identitetsarbejde med patienterne. Afhandlingen nærmer sig derfor spørgsmålet om brugerinddragelse ved at spørge: Hvordan konstitueres identiteter som psykiatriske patienter diskursivt? Hvilke implikationer har dette for at involvere patienternes perspektiver i behandlingen?

Afhandlingen benytter sig af en etnografisk metodologi for at studere mødet mellem patienter og professionelle samt hvordan mening konstrueres, produceres og reproduceres i dette. Metoderne består af tre måneders deltagerobservation i to psykiatriske institutioner i Danmark - en psykiatrisk klinik og et ”lukket” sengeafsnit - og interview med 13 patienter og 11 tværfaglige professionelle. Teoretisk finder undersøgelsen inspiration i Foucaultske perspektiver på diskurser, normer og viden samt psykologisk diskursteori, herunder især positioneringsteori.

Afhandlingen indleder med at introducere undersøgelsen og nogle af de kontroverser og debatter der omgiver den moderne psykiatri. *Kapitel 2* diskuterer uddrag af den eksisterende, primært kvalitative, forskning om psykiatriske patienter, professionelles praksisser og brugerinddragelse, og diskuterer denne undersøgelses mulige bidrag. *Kapitel 3* præsenterer kort psykiatrien ud fra et historisk og moderne idehistorisk perspektiv og diskuterer den nutidige danske psykiatris funktioner og struktur. Det næste kapitel, *kapitel 4*, diskuterer afhandlingens teoretiske og metodologiske perspektiver: ideen om situeret viden, Foucaultske perspektiver på sprog, diskurser og viden samt psykologisk positioneringsteori. I *kapitel 5* præsenteres undersøgelsens design, metoder og de konkrete settings i hvilke feltarbejdet blev udført, såvel som reflek-

sioner over forskningsetik og den analytiske proces. Undersøgelsens resultater diskuteres i tre artikler, der tilsammen udgør afhandlingens analyse i *kapitel 6*. Den første artikel nærmer sig forskningsspørgsmålet fra en metodologisk ramme; den analyserer processer af forskerpositionering i løbet af feltarbejdet som empiri - og demonstrerer hvordan disse blev til kilder til viden om de diskursive normer i feltet. Den anden artikel analyserer diskurser om psykisk sygdom i institutionerne og undersøger disses implikationer for patienterne. Den tredje artikel udforsker de professionelles praksisser af brugerinddragelse og de muligheder og begrænsninger der opstod i deres diskursive kontekst. I afhandlingens *konklusion* samles der op på resultaterne, og disse diskuteres i relationen til ønsket om at fremme en mere involverende tilgang i psykiatrien.

Analyserne peger på at patienterne inviteres til at tilegne sig de dominerende forståelser i institutionen, hvis de ønsker at blive involveret i behandlingen. Afhandlingen kortlægger tre institutionelt forankrede måder at tænke og tale om patienternes problemer i form af psykisk sygdom: ustabilitetsdiskursen, ”rigtigt syg” diskursen og manglende sygdomsindsigtsdiskursen. Disse diskurser bringer specifikke måder at visualisere psykisk lidelse i forgrunden, hvilket medfører at andre udtryk for lidelse ofte opfattes som ikke-autentiske eller problematiske. Patienterne er nødt til at udvikle en finfølelse og præcis sans for diskurserne og lave strategiske overvejelser om hvordan de fremstår over for de professionelle, hvis de ønsker at have medindflydelse i behandlingen. Patienter, for hvilke det ikke lykkes at aflæse normerne på den ”rigtige måde”, risikerer at blive uforståelige for de professionelle, problematiseret, eller at få deres forståelser afvist. Samtidig viser afhandlingen at både patienter og professionelle finder måder, hvorpå de kan yde modstand mod de dominerende diskursive normer. Ligesom patienterne er de professionelle også nødt til at navigere i et modsætningsfuldt felt. På den ene side er deres arbejde indskrevet i etiske idealer om ligeværdighed og om at lytte til patienterne, på den anden side er deres positioner funderet i en teknisk diskurs om ekspertviden. At involvere patienternes perspektiver bliver derfor til en kompleks og vanskelig balancegang for de professionelle, der ofte indebærer, at diskursive normer subtilt skal genforhandles. Denne genforhandling resulterer sjældent i mere end individualiserede løsninger, hvor der ”laves en undtagelse”. Afhandlingen peger endvidere på, at i spørgsmålet om definitioner af patienternes problemer kan patienternes egne forståelser og oplevelser kun inddrages i meget begrænset grad, hvis disse strider mod dominerende psykiatriske definitioner.

Ligesom diskurserne skaber normer, der former hvordan patienter og professionelle kan defineres på, så skabte de også rammer for hvordan forskeren kunne forstås af deltagerne i løbet af feltarbejdet. Igennem feltarbejdet blev kategorierne ”patient”, ”professionel” og det binære par ”patologi” og ”normalitet” til en strukturerende norm i forskerens interaktioner med deltagerne. Disse binære par efterlod meget lidt plads til at forhandle positioner imellem og formede hvordan deltagerne kunne interagere med forskeren. Der argumenteres således for, at dette peger på at de diskursive normer var brede og fast forankret i institutionelle processer, snarere end blot manifestationer af individuelle deltagers karakteristik.

Resultaterne diskuteres i forhold til de nye forsøg på at implementere en mere inkluderende og involverende psykiatri. Analyserne stiller spørgsmålstejn ved i hvor høj grad psykiatriske patienter rent faktisk kan have indflydelse over behandlingen, når det at få indflydelse ofte forudsætter at de skal tilegne sig de fremherskende forståelser i institutionen, og til tider afvise deres egne, for at blive hørt. På baggrund af analyserne argumenteres der for, at for at kunne praktisere en mere demokratisk grad af brugerinddragelse, er de professionelle nødt til at blive støttet af et system der er mere åbent for multiple definitioner af psykisk lidelse og patienthed, i deres forsøg på at involvere patienternes perspektiver. Ligeledes peges der på vigtigheden af at involvere brugerne af det psykiatriske system i langt højere grad til at udvikle modeller for brugerinddragelse. Dette kan åbne op for, at mangfoldigheden og diversiteten i patienternes perspektiver tages alvorligt, også når disse adskiller sig betydeligt fra traditionelle psykiatriske forståelser. Afhandlingen åbner således op for en diskussion om hvordan psykiatrisk viden konceptualiseres i psykiatriske praksisser samt de implikationer dette har for patienter og professionelle.

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Appendices

Appendix 1: Information letter about the study

Sprog og værdier i psykiatrien - et ph.d. projekt om hvad det vil sige at være psykiatrisk patient

Agnes Ringer, cand.psych., ph.d.-stipendiat ved Region Sjælland Psykiatri og Institut for Psykologi og Uddannelsesforskning, Roskilde Universitet

Vejleder: Annegrethe Ahrenkiel, ph.d., lektor, PAES, RUC

Bivejleder: Erik Simonsen, ph.d., professor, forskningschef i Region Sjælland Psykiatri

Beskrivelse af projektet

Projektet vil undersøge hvad det indebærer at være patient i psykiatrien i dag. Indgangsvinklen til dette er et fokus på sprog, historier og kommunikation i psykiatrien. Især fokuserer undersøgelsen på mødet mellem patienter og tværfaglige professionelle. Hvordan opfattes det at være patient? Hvad sker der i samtalerne mellem patienter og professionelle? Forhandles der om hvad det vil sige at være patient og kan dette lede til nye opfattelser? Projektet har til formål at bringe ny viden om patienters positioner og hvordan disse eventuelt forandres i den nutidige psykiatri.

Fremgangsmåde og teori

Den empiriske del af projektet foregår på to psykiatriske afdelinger i Region Sjælland, en distriktspsykiatrisk afdeling og et sengeafsnit. Metoderne i projektet er deltagerobservation, interviews, lydoptagelser og analyser af skriftligt materiale (patientjournaler, pjecer mv.).

Studiet undersøger hvordan patienter og professionelle skaber mening og interagerer i deres specifikke sociale og kulturelle kontekst. Målet er således at se på, hvordan forskellige meninger og praksisser i forhold til at være patient konkret opstår i en psykiatrisk kontekst. Undersøgelsen henter inspiration fra konstruktionistisk teori.

Etiske aspekter

Projektet har kontaktet Datatilsynet og Region Sjællands Videnskabsetiske komité om tilladelse til at gennemføre studiet. Projektet vil overholde Datatil-

synets retningslinjer for indsamling og opbevaring af empirisk materiale. Dette indebærer, at alle oplysninger der indhentes, bliver behandlet fortroligt, opbevares utilgængeligt for andre og anonymiseres, så ingen af deltagerne vil kunne genkendes. Båndoptagelserne fra interviewene vil blive slettet efter udskrivning.

De involverede afsnit vil blive informeret om undersøgelsen, og mundtlige og skriftlige samtykkeerklæringer vil indhentes fra personalet og de involverede patienter. Afsnittene kan på et hvilket som helst tidspunkt trække sig fra undersøgelsen. Tilsvarende kan de enkelte personer fra personalet og de involverede patienter når som helst trække deres tilsagn til deltagelse tilbage.

Hvad indebærer det at deltage i undersøgelsen?

For de involverede afsnit indebærer undersøgelsen kun lidt ekstraarbejde. Udgangspunktet for studiet er, at afsnittene og personalet først og fremmest skal gøre som de ”plejer” under observationerne. Ud over dette vil projektet indebære enkelte interviews med personale fra forskellige faggrupper og interviews med patienter. Disse vil i højst mulig grad blive tilrettelagt, så de ikke forstyrrer planlagte patientforløb. Udover dette vil en nøgleperson (fx en afdelingsleder) til en vis grad skulle hjælpe med indsamling af skriftligt materiale såsom vejledninger, pjecer, patientjournaler mv.

Jeg ser frem til samarbejdet med jer!

Skulle I have spørgsmål til projektet er I velkommen til at kontakte:

Ph.d.-stipendiat Agnes Ringer

Mail: agmr@regionsjaelland.dk / agnesri@ruc.dk

Mobil: 24 96 44 73

Appendix 2: Information poster for the ward

ROSKILDE UNIVERSITET



Hvad vil det sige at være patient i psykiatrien?

Mit navn er Agnes Ringer. Jeg er i gang med at uddanne mig til forsker og laver et forskningsprojekt, hvor jeg prøver på at forstå hvordan det er at være patient i psykiatrien og hvordan personalet og patienterne taler med hinanden. Jeg kommer derfor til at være herude på afsnittet et par dage om ugen fra slutningen af maj og lidt over en måned frem. Forskningsprojektet er et led i en forskningsuddannelse på Roskilde Universitet. På baggrund af projektet vil jeg skrive en bog – den afsluttende ph.d.-afhandling.



Må jeg hilse på dig?

Min første dag på afsnittet kommer jeg gerne rundt på stuerne og hilser på jer der bor her, og bagefter vil jeg gerne være her et par dage om ugen. Jeg vil meget gerne lære fra jer, hvordan I oplever det at være her, og hvordan det er at være patient i psykiatrien. Hvis det er ok med jer, kommer jeg også gerne med til nogle af de samtaler I har med personalet.

Alle der deltager i projektet er anonyme:

- Jeg vil ikke dele det du fortæller mig med nogen andre, hverken personalet i psykiatrien, andre patienter eller andre forskere
- I min afhandling vil jeg ikke bruge nogen personlige oplysninger, der ville kunne spores tilbage til dig
- Hvis jeg bruger noget af det du fortæller mig i afhandlingen, vil jeg gøre det i anonymiseret form - på en måde så du ikke vil kunne genkendes

Det er frivilligt at deltage i undersøgelsen, og du kan når som helst bede mig om at gå, hvis du har brug for en pause, eller hvis der er noget du ikke har lyst til at jeg er med til.

Jeg glæder mig til at komme ud og hilse på jer!

Agnes Ringer, ph.d.-studerende, Roskilde Universitet
Mail: agnesri@ruc.dk

Institut for Psykologi- og Uddannelsesforskning
Roskilde Universitet
Postboks 260
4000 Roskilde

Appendix 3: Informed consent for interview

Informeret samtykke: forskningsprojekt om sprog i psykiatrien

Jeg vil gerne spørge om du vil deltage i følgende anonyme undersøgelse:

Formål

Projektet hedder "Sprog og værdier i psykiatrien". Det handler om at forstå hvordan personalet taler med patienter og hvordan det er at være patient i psykiatrien. I projektet vil jeg gerne interviewe patienter og nogle behandlere, samt være med til jeres samtaler. Jeg er derfor interesseret i din oplevelse af psykiatrien og hvad du tænker om det at være patient i psykiatrien.

Hvem er jeg?

Mit navn er Agnes Ringer. Jeg er i gang med at uddanne mig til forsker på Roskilde Universitet. Undersøgelsen er et led i forskeruddannelsen og skal bruges til at skrive en bog – den afsluttende ph.d. afhandling.

Anonymitet og tavshedspligt

Din deltagelse i undersøgelsen er anonym. Dette indebærer at der er visse regler som jeg vil overholde:

- Jeg har tavshedspligt og vil ikke dele det du fortæller mig med nogen andre, hverken personalet i psykiatrien, andre patienter eller andre forskere
- Jeg vil ikke bruge dit navn, cpr-nummer eller andre oplysninger som kan føres tilbage til dig. Alle de oplysninger jeg får, bliver behandlet fortroligt og anonymiseres, så du ikke vil kunne genkendes i afhandlingen
- Båndoptagelserne fra interviewene og samtalerne vil blive slettet efter udskrivning. Dette gør jeg for at sikre dig anonymitet

Interview

Samtalen varer ca. 1 time og før vores samtale vil jeg bede dig om at underskrive samtykkeerklæringen nederst. Interviewet vil blive optaget på bånd, udskrevet til tekst, og dele af dem vil i anonymiseret form kunne indgå i afhandlingen.

Jeg vil også bede dig om samtykke til, at jeg får adgang til dele af din patientjournal. Jeg vil ikke bruge journalen til at få personlige oplysninger om dig, men til at se på hvordan personalet skriver om deres patienter.

Det er frivilligt at deltage i undersøgelsen, og selvom du har givet tilsagn om at deltage, kan du når som helst trække dit tilsagn tilbage.

Har du spørgsmål til undersøgelsen, er du meget velkommen til at kontakte mig:

Agnes Ringer, ph.d.-studerende, Roskilde Universitet
Mail: agnesri@ruc.dk

Institut for Psykologi- og Uddannelsesforskning
Roskilde Universitet
Postboks 260
4000 Roskilde

INFORMERET SAMTYKKE

Tilsagn vedrørende deltagelse i undersøgelsen "Sprog og værdier i psykiatrien"

Navn: _____

Fødselsdato: _____

☐ (Sæt kryds) Jeg giver samtykke til at deltage i undersøgelsens interview

☐ (Sæt kryds) Jeg giver samtykke til, at undersøgeren får adgang til min patientjournal

Jeg er bekendt med, at det er frivilligt at deltage i undersøgelsen, og at jeg når som helst kan trække mit tilsagn tilbage. Jeg har fået en kopi af denne samtykkeerklæring til eget brug.

Dato

Underskrift

Ovenstående skriftlige og mundtlige information er givet af:

Dato

Underskrift

Appendix 4: Interview guide for patients

I. Hvilke narrativer har informanterne om livet før, og grunden til at de er i psykiatrien?

- Prøv på at fortælle lidt om dit liv før du kom i kontakt til psykiatrien?
- Prøv på at fortælle mig lidt om hvad der ledte til at du kom i kontakt til psykiatrien første gang?
 - Hvad skete der så?
 - Hvad tænkte du om det?
 - Kan du fortælle lidt mere om det?
 - Har du nogen eksempler på det?

II. Hvordan oplever informanterne livet i psykiatrien og psykiatriens sprog?

- Hvis du prøver på at huske tilbage til din kontakt med psykiatrien, kan du fortælle mig om nogen episoder som især har været betydningsfulde for dig?
 - Fx første kontakt?
- Hvordan oplever du nu det at have kontakt til psykiatrien?
- Hvad synes du især har været betydningsfuldt for dig i din kontakt med psykiatrien?
- Har du været uenig i noget som blev sagt om dig? Hvad skete der så?
- Har dine forståelser for dig selv ændret sig siden du fik kontakt til psykiatrien?

Forskningsspørgsmål: Hvordan oplever informanterne deres deltagelsesmuligheder i psykiatrien?

III. Hvordan oplever informanterne deres deltagelsesmuligheder i psykiatrien?

- Oplever du at de lytter til dig i psykiatrien?
- Kan du give nogen eksempler? Er der eksempler på det modsatte?
- Oplever du at du er med i de beslutninger som træffes om dig?
- Hvordan/hvordan ikke? Kan du give et eksempel?
- Hvordan tror du at andre patienter oplever det at være i psykiatrien?

- Er der noget vigtigt jeg har glemt at spørge om? Eller som du synes er vigtigt?

Appendix 5: Interview guide for professionals

I. Baggrundsspørgsmål

- Hvor gammel er du? Hvor længe har du arbejdet i psykiatrien? Hvad er din uddannelsesmæssige baggrund? Hvor længe har du været her i teamet?
- Hvor mange patienter har du?
- Hvordan ser en typisk arbejdsdag ud for dig?

II. Hvordan tilskriver informanterne mening til deres arbejde i psykiatrien og deres patientforløb?

- Hvad var det der gjorde at du valgte at arbejde i psykiatrien?
- Hvad ser du som din rolle i psykiatrien?
- Hvad ser du som psykiatriens formål?
- Hvis du kigger tilbage på dine samtaler med patienter, kan du fortælle mig om nogen samtaler som især har været betydningsfulde for dig?
- Har du nogen eksempler på en kontakt med en patient som var rigtig god?
- Har du nogen eksempler på en kontakt med en patient som var rigtig dårlig?
- Så vil jeg gerne spørge dig konkret om nogle af de patienter du har nu...

III. Hvordan oplever informanterne deres arbejdssituation og hvilke betingelser påvirker deres kontakt til patienterne?

- Har du oplevet at din arbejdssituation har ændret sig siden du startede? Hvis ja - hvordan? Kan du give nogle eksempler?
- Hvad tror du det kan have betydet for din kontakt med patienterne?
- Hvad oplever du som det bedste ved at arbejde her?
- Hvad oplever du som det sværeste ved at arbejde her?
- Har du nogensinde været uenig i den måde ting blev gjort på i psykiatrien?

IV. Hvad tænker informanterne om brugerstyring?

- I psykiatrien tales der meget om brugerstyring – er det noget du har tænkt over? Kan du nævne nogen eksempler på det?
- Hvornår ville du sige, at noget var brugerstyret?
- Hvornår ville du sige, at noget ikke var brugerstyret?
- Er der noget vigtigt vi ikke har talt om?

Appendix 6: Convention of interview transcripts

The choice of transcription conventions should be closely related to the type of analysis one wishes to conduct. My concern in the interviews and the recordings of meetings was primarily with the content of the talk and the broader patterns of what was being said. I was less interested in the fine linguistic details and the small moment-by-moment mechanism in the interviews. For this reason I adopted the simplified version of the classic Jeffersonian transcript convention developed by Wetherell & Potter (1992:226). The main conventions are shown beneath:

// - starts of overlap in talk

(.) – A pause, only timed if it lasts exceptionally long

... – omitted material (in the particular extract used in the example)

(yeah, aha) – Comments from the interviewer, tokens of acknowledgement are placed in round brackets within the text of the interviewee

[inaudible] – Clarification or explanatory material is placed in square brackets

I felt so bad – words said with particular emphasis are underlined

She said "I like you" - when the interviewee refers to someone else saying something, this is marked with citation signs

Sounds that are not actual words such as "Uhm", "er" are included, and commas, full stops and question marks are placed to improve the readability of the extracts, and in an attempt to convey the sense as heard in the recording.

Appendix 7: Diagnostic criteria for schizophrenia and borderline personality disorder

ICD-10 (WHO, 1993) diagnostic criteria for schizophrenia

F20 - F29 SCHIZOPHRENIA, SCHIZOTYPAL AND DELUSIONAL DISORDERS

F20-F29

Schizophrenia, schizotypal and delusional disorders

F20 Schizophrenia

F21 Schizotypal disorder

F22 Persistent delusional disorders

F23 Acute and transient psychotic disorders

F24 Induced delusional disorder

F25 Schizoaffective disorders

F28 Other nonorganic psychotic disorders

F29 Unspecified nonorganic psychosis

F20.0 - F20.3

General criteria for Paranoid, Hebephrenic, Catatonic and Undifferentiated type of Schizophrenia:

G1. Either at least one of the syndromes, symptoms and signs listed below under (1), or at least two of the symptoms and signs listed under (2), should be present for most of the time during an episode of psychotic illness lasting for at least one month (or at some time during most of the days).

(1) At least one of the following:

- a) Thought echo, thought insertion or withdrawal, or thought broadcasting.
- b) Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception.
- c) Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him between themselves, or other types of hallucinatory voices coming from some part of the body.

d) Persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g. being able to control the weather, or being in communication with aliens from another world).

(2) or at least two of the following:

e) Persistent hallucinations in any modality, when occurring every day for at least one month, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent over-valued ideas.

f) Neologisms, breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech.

g) Catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism and stupor.

h) "Negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses (it must be clear that these are not due to depression or to neuroleptic medication).

G2. Most commonly used exclusion criteria: If the patient also meets criteria for manic episode (F30) or depressive episode (F32), the criteria listed under G1.1 and G1.2 above must have been met before the disturbance of mood developed.

G3. The disorder is not attributable to organic brain disease (in the sense of F0), or to alcohol- or drug-related intoxication, dependence or withdrawal

ICD-10 (WHO, 1993) Diagnostic criteria for emotionally unstable personality disorder, borderline type

F60 SPECIFIC PERSONALITY DISORDERS

F60.0 Paranoid personality disorder

F60.1 Schizoid personality disorder

F60.2 Dissocial personality disorder

F60.3 Emotionally unstable personality disorder

.30 Impulsive type

.31 Borderline type

F60.4 Histrionic personality disorder

F60.5 Anankastic personality disorder

F60.6 Anxious [avoidant] personality disorder

F60.8 Other specific personality disorders

F60.9 Personality disorder, unspecified

F60 SPECIFIC PERSONALITY DISORDERS

G1. Evidence that the individual's characteristic and enduring patterns of inner experience and behaviour deviate markedly as a whole from the culturally expected and accepted range (or 'norm'). Such deviation must be manifest in more than one of the following areas:

- (1) cognition (i.e. ways of perceiving and interpreting things, people and events; forming attitudes and images of self and others);
- (2) affectivity (range, intensity and appropriateness of emotional arousal and response);
- (3) control over impulses and need gratification;
- (4) relating to others and manner of handling interpersonal situations.

G2. The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations (i.e. not being limited to one specific 'triggering' stimulus or situation).

G3. There is personal distress, or adverse impact on the social environment, or both, clearly attributable to the behaviour referred to under G2.

G4. There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence.

G5. The deviation cannot be explained as a manifestation or consequence of other adult mental disorders, although episodic or chronic conditions from sections F0 to F7 of this classification may co-exist, or be superimposed on it.

G6. Organic brain disease, injury, or dysfunction must be excluded as possible cause of the deviation (if such organic causation is demonstrable, use category F07).

Comments: The assessment of G1 to G6 above should be based on as many sources of information as possible. Although sometimes it is possible to obtain sufficient evidence from a single interview with the subject, as a general rule it is recommended to have more than one interview with the person and to collect history data from informants or past records. It is suggested that sub-criteria should be developed to operationalize behaviour patterns specific

to different cultural settings concerning social norms, rules and obligations where needed (such as examples of unresponsibility and disregard of social norms in dissocial personality disorder). The diagnosis of personality disorder for research purposes requires the identification of a subtype (more than one subtype can be coded if there is compelling evidence that the subject meets multiple sets of criteria).

F60.3 Emotionally unstable personality disorder

F60.30 Impulsive type

A. The general criteria of personality disorder (F60) must be met.

B. At least three of the following must be present, one of which is (2):

- (1) A marked tendency to act unexpectedly and without consideration of the consequences.
- (2) A marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized.
- (3) Liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions.
- (4) Difficulty in maintaining any course of action that offers no immediate reward.
- (5) Unstable and capricious mood.

F60.31 Borderline type

A. The general criteria of personality disorder (F60) must be met.

B. At least three of the symptoms mentioned above in criterion B (F60.30) must be present, and in addition at least two of the following:

- (6) Disturbances in and uncertainty about self-image, aims and internal preferences (including sexual).
- (7) Liability to become involved in intense and unstable relationships, often leading to emotional crises.