Patient identities, stories and language in Psychiatry

Contents

1. Basics

Involved in the study:
Agnes Ringer, M.sc. psychology, PhD candidate
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Erik Simonsen, M.D., Ph.D., Professor, co-supervisor

Field:
Two psychiatric wards in Region Sjælland: one outpatient and one inpatient

Aim of the study:
To investigate the connection between language and stories in psychiatry and the patients' notions of subjectivity and identity. To explore what happens when patients interact with the staff and what this may mean to patients and their possibilities for participating in psychiatry.

Methods:
Observations of patient-professional interactions, interviews with patients and professionals, analysis of patient records. A pilot-project will be conducted prior to the main study. The material will consist of field notes, interview transcripts and patient records. The data are analyzed from a constructionist perspective, inspired by narrative and discursive psychology and institutional ethnography.

Information to participants
Meetings and presentations for ward managers and professionals
Information letters about the project, for patients and professionals
Informed written consent will be acquired from patients for participating in interviews and getting access to their patient records
Informed oral consent from professionals participating in interviews
Informed oral consent from patients and professionals for observations

2. Background

The recent decades have seen a rising interest in the relationship between patients and professionals in psychiatry, and concepts like "service user involvement" and "empowerment" are gaining increased popularity. In Denmark, the promotion of service user involvement, defined as "treatment […] based on co-operation between the patient and the clinician, taking as its starting point the patient's experiences and wishes" (Region Sjælland Psykiatrien, 2010a [my translation]) is now part of both regional and national mental health policy agendas (cf. ibid., Danske Regioner, 2009; Region Sjælland Psykiatrien, 2008; 2010b).

Recognizing the importance of language and relationships in promoting service user involvement, this has brought a demand for research that explores language and the interactional patterns between patients and professionals in psychiatry. Meanwhile, these types of studies remain relatively sparse in psychiatric research. A preliminary literature search reveals that most qualitative studies on patient-professional interaction are found in nursing journals (CINAHL) and analyze how mental health nurses communicate with patients (e.g. Adams, 2000; Adams, 2001; Bowers, 2010; Cutcliffe & Happell, 2009; Hamilton & Manias, 2006; Middleton & Uys, 2008; Robertson et al., 2010).

The focus on the *nurse* (and not other professional groups) in research on patient-professional interaction is comprehensible, since person-centeredness and actively engaging in the lifeworld of

the patients are considered some of the core qualities of nursing (Middleton & Uys, 2009). However, since the interdisciplinary professionals in psychiatry have different functions and backgrounds, the patterns of patient-professional interaction may vary significantly within different professional groups (Warne & Stark, 2004). This indicates a need for studies that explore patient communication with other mental health professionals than nurses and with members of multidisciplinary teams.

Furthermore, as Buus (2005) notes, studies on nurses' communication in psychiatry often compare their real-life observations to theoretical ideals of nursing, and thus focus on the gap between professional ethics and everyday practice. These types of normative comparisons minimize the importance of the institutional context in the interaction. Consequently, they may result in a tendency to "blame the victim" (the nurse) for not living up to the ethical ideals of the profession, failing to recognize that the interaction is situated within a specific institutional context, with specific expectations, rules and procedures (see Buus, 2005 for a more extensive discussion).

Utilizing interviews with patients and professionals, as well as observations of patient-professional interactions, this project studies the experiences and everyday interactions of patients and multidisciplinary professionals at two wards in Denmark. The study addresses the issue of language, discourses and storytelling by adopting a 'moderate' social constructionist approach, in which language is seen as co-constitutive (but not totally encompassing) of social reality and identities (Burr, 1995).

It is not the intention of the study to evaluate the language used in psychiatry in terms of bad, good or best language, or to compare it to a set of predefined standards. Rather, the aim is to explore what the language and narratives may *produce* in terms of positions and self-understandings for the patients (Hamilton & Manias, 2006). In the following sections, the study's aims, research questions, theoretical and methodological perspectives, as well as a review of some previous studies are outlined.

3. Aim of the study and research questions

Within the constructionist perspective, language is not simply a description of reality. Rather it has a function and an effect within an interaction: a performative aspect. Instead of studying language and discourse as a route to discovering some aspects of an "underlying reality" or "underlying personality", language and stories become the object of study itself. People engaged in any conversation are seen as engaged in mutually constructing who they are (Davies & Harré, 1990). The

language used in psychiatry and the interactions the patients have with the staff may therefore have an impact on the patients' understanding of who they are and the role they play in psychiatry.

Inherent in psychiatry, as in any institution whose task is to help, treat or provide care for people with social problems, there are also specific self-stories that patients are anticipated to assume (Gubrium & Holstein, 2001). In the encounter with the mental health professional, the patient's problems become categorized, diagnosed and conceptualized according to the understandings prevailing in the institution. In this light, psychiatry is not neutral - it cannot solely offer help based on the wishes and needs of the patients (ibid.). Psychiatry's view is also based on professional and cultural notions of what it means to be a person, and what constitutes personality and mental illness (Barker & Stevenson, 2000). This implies that the study cannot only study the micro-interactions between individual patients and professionals. It must also explore the self-understanding and positions available to patients within the institution of modern psychiatry.

Acknowledging the above, the research questions of the study become:

How are patient identities negotiated in patient-professional interactions in psychiatry and what do these mean for the patients' self-understandings and possibilities for participation?

Related sub questions are:

How are patients positioned and position themselves in patient-professional interactions? How are patient identities constructed in the absence of patients? How do psychiatric patients construct self-stories in relation to their experiences in psychiatry?

What type of positions and stories are available to patients within the institution of psychiatry? What role do institutional discourses about patient identities play in the patient-professional talk? What role may they play in the patients' own self-narratives?

4. Project Design

The overall method of generating data is qualitative fieldwork (participant observation) at two psychiatric institutions in Denmark: one out-patient clinic and one in-patient 'closed' ward. My main motivation for choosing two different institutions is a striving for diversity (e.g. Denzin, 2006). One may expect the everyday life, the perception of patients and the institutional cultures of an inpatient and outpatient psychiatric ward to vary significantly. Thus, if it is possible to point to similar patterns across the wards, despite their differences, this may strengthen the results. If, however, there will be significant variations in the patterns, these may contribute to an understanding of the great

complexity and local constructions of the institution. A striving for diversity is also what compels me to make use of numerous qualitative methods in the project:

- A pilot study with participant observation prior to the main fieldwork
- *Observations and recordings* of everyday interactions between patients and multi-disciplinary professionals (admittance interviews, group therapy, supportive talks, follow-ups on medication etc.) as well as of staff meetings.
- *Recorded interviews with patients* focusing on their experiences of psychiatry and understandings of user involvements
- *Recorded interviews with professional* focusing on their perceptions of patient identities, user involvement and their work
- *Text analyses of patient records* and some policy documents

Oral consent will be attained from patients and professionals prior to the observations. Written informed consent will be attained from patients prior to conducting interviews and getting access to their patient records.

The study is essentially explorative and I wish to refrain from evaluation. In the analysis, I will try to be as open as possible and attempt to follow the ethnomethodological principle of 'indifference' - meaning not letting grand theories about power relations and political agendas determine the analysis (Schegloff, 1997). At the same time I am aware that as a researcher I have personal and theoretical presuppositions that I bring to the field and analysis. I therefore find it important to account for these thoroughly throughout the thesis, following the standards of quality in qualitative research as outlined e.g. by Elliot, Fischer & Rennie (1999) and Kvale & Brinkmann (2009). In the study, I will therefore provide extensive descriptions of my theoretical, personal and empirical knowledge of the field, giving the reader a possibility to evaluate the quality of my analysis and interpretations.

5. Contribution to existing research

In this short and selective review of research on language in psychiatry, I will limit myself mostly to qualitative studies, since they are closer to the methodology that I am applying in the project. The qualitative traditions within the field of psychiatry may roughly be divided into two traditions – discourse analyses of psychiatric practice and research on patients' experience. As will become obvious in the next section of the project protocol, this project represents an attempt to blend the two traditions.

Many studies indicate that patient-professional communication in the health sectors has a significant influence on patient satisfaction, the rate of mistakes committed by the professional and the results of the treatment (Roter & Hall, 2006; Roberts, 2009). Meanwhile, discourse analyses seem to suggest that despite the official policy of user involvement in psychiatry, the communication between patients and professionals is still characterized by a predominantly biomedical model, with an instrumental view of the patient as a recipient of treatment (e.g. Avdi, 2005; Hodge, 2005; Hui & Stickley, 2007; Middleton & Uys, 2008; Rose, 2003; Stevens & Harper, 2007). Middleton & Uys (2009) conducted an analysis of seven transcripts of interactions between nurse students and patients in South Africa. They found that almost all sequences in the texts were organized around cycles of questions from the nurses and responses from patients, allowing the nurses to control the conversations. Furthermore, the questions asked were mostly close-ended and the patients' responses were only selectively taken up. The authors concluded that the knowledge constructed in the interactions was not consistent with the person-centered ideals of the nursing profession, but rather adhered to the institutional authority of the psychiatric clinic. Hamilton et al. (2004) conducted a Foucauldian discourse analysis of interview transcripts of a nurse, a social worker and a psychiatrist during assessment practices. The analysis indicated that all professionals' language use, albeit differing in degree and presentation, was embedded in a bio-medical framework of the 'medical gaze' and management-like discourse that marginalized the perspective of patients.

The philosopher Mark Roberts (2009) argues that the language used in psychiatry and in the patient-professional interaction is of crucial importance for the patient to feel co-responsible and engaged in the treatment. Drawing on Deleuze's theories of active and reactive forces, Roberts argues that if a mental illness is solely conceptualized as *reactive* – consisting of deficiencies such as a lacking sense of reality and rationality – the person with the illness will be 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. Furthermore, patients are "invited" into the psychiatric terminology. They start to internalize the psychiatric models of explanation and to understand their own potential and identity as reflections of them. According to Roberts (2009), in this process the person's existential repertoire of actions is minimized. Thus, the patients' possibilities for active participation are limited by the power relations that occur in the interaction with the psychiatric institution.

At the same time, studies on patient experiences of psychiatry suggest that the standard language of psychiatry and the practices of psychiatric observation, assessment and treatment need not be intrinsically problematic. Some studies indicate that patients feel empowered e.g. by the medical

orientation of a diagnosis because it legitimizes the illness and thus reduces some of the social stigma associated with being mentally ill (Hayne, 2003; Jonsdottir et al., 2004). Furthermore, studies on patient experiences also suggest that many patients and ex-patients report that the psychiatric treatment has improved their quality of life (Middleton & Uys, 2008).

This discrepancy may be a question of the researchers' choice of analytic strategies and methodology. One limitation of discourse analytical studies of psychiatric practice is that many focus only on interpretations of what is going on in the interactions between professionals and patients. Language and context are often emphasized to such a degree that the experiences of patients become bracketed if not totally removed. Thus, they often fail to ask what meanings and consequences the interactions may have for the patient. On the other hand, research on patients' experience may tend to romanticize self-experience and thereby not acknowledge the significance of language or the relations of power and domination inherent in the patient-professional interaction. As will become apparent, the theoretical framework of this project presents an attempt to unite the two traditions.

6. Theoretical and analytical framework

Positioning theory : patient positions in talk-in-interaction

Discourse analyses of communication within psychiatry often focus on *one* party in the professional - patient dyad: the professional (as a representative of the institution) and how she/he constructs power and domination linguistically in the encounter (Thompson, 1984). This is the aim of Foucauldian inspired analyses (such as Hamilton et al, 2004, mentioned above) in which psychiatry is seen as a place of discipline and containment for deviants, legitimized by the 'medical gaze' (e.g. Foucault, 1989; Miller & Rose, 1986). Although these types of analysis provide important insights into some of the functions and discourses of psychiatry, as stated above, they reveal little about the experiences of patients within the institutions. Additionally, they may have a too deterministic view of how identities are constructed, understating the notion of personal agency (Benwell & Stokoe, 2006).

This project wishes to study the patient-professional interactions as a bidirectional process, drawing on the concept of *positioning*, borrowed from positioning theory (Davis & Harré, 1990; Harré & Langenhove, 1999). In a previous section, I noted that according to discursive psychology, people in conversations are engaged in mutually constructing a diversity of selves. According to Harré & van Langehove (1999), positioning is the process in which this construction of selves occurs. Harré & van Langenhove claim that in any conversation people are positioning themselves, positioning others, or

are being positioned by others. For example, speakers can position themselves (and others) as active or passive, powerless or powerful, competent or incompetent and so on. The positions also have social consequences and functions, e.g. if a person is positioned as incompetent in a certain area, she may not be accorded the right to contribute to discussions on that field (ibid.)

Positioning may be either intentional and conscious or unintentional and tacit (Davies & Harré, 1990). The positions in a conversation are made available through the 'master narratives' (also referred to as 'master discourses' or 'story lines') of a culture, which are intimately connected to social power relations. However, a person may disagree with a positioning, challenge it or refuse it. In that case, a negotiation occurs, where a secondary positioning may be agreed upon. Thus, people may refuse, negotiate or modify positions, preserving personal agency.

In the study, I will use the positioning concept as a way of exploring the interactions between patients and professionals in psychiatry. The project will study both how the patients position themselves in interactions and how they are positioned by, and position the professional. The non-determinist and bidirectional characteristics of the positioning concept is helpful, in that I do not necessarily assume that all patients uncritically take up the positions offered by professionals in the interaction and vice versa.

Subjective experience as narratively structured

Positioning theory was developed as a conceptual apparatus for discourse analysis (Harré & Langenhove, 1999). A significant strength of positioning theory in regard to the project is that it provides a sensitive and useful framework for understanding what is going on in the patient-professional interactions. What may become unclear, however, as in most discursive approaches, is *who* is using the language or rhetoric strategies and how it happens (Alvesson & Karreman, 2000). In other words, one may wonder: 'What is going on inside human beings when they use discourse?' (Parker, 1991, p. 83). Although positioning theory acknowledges that people experience a sense of continuity, in that "[h]uman beings are characterized both by continuous personal identity and by discontinuous personal diversity" (Davies & Harré, 1990, p. 46), it is less concerned with personal identity or subjective experience, and more concerned with the moment-to-moment multiple selves of talk-in-interaction (ibid., p. 47).

One of the aims of this project is to study the subjective and experiential realities of the agents within psychiatry. Hence, the project needs a framework that can account for how the multiplicities of selves that arise in interactions are connected to the patients' continuous notion of subjectivity. Narrative psychology presents such a framework, and will therefore be used in the project. The

narrative psychological perspective shares the poststructuralist and discursive concern with language as an instrument for constructing reality and selves. As in positioning theory, the experience of self is seen as meaningful only through specific linguistic, historical and social structures. The aim of narrative psychology is therefore to study the language, stories and narratives that constitute selves and their implications for individuals and societies. As such, it is entirely consistent with positioning theory and other discursive approaches. However, the narrative psychological approach aims specifically at understanding the personal experiences undergone by individuals (Crossley, 2000). Narrative psychology assumes that human experience has an essentially narrative structure, and argues that the idea of *narrative* adds an important component to discourse based theories of identity construction: the notion of temporality (Benwell & Stokoe, 2006). Through narratives, humans attempt to impose temporal structure on the flow of experience, which produces a sense of identity coherence. One of the central premises of narrative psychology is therefore that there is a fundamental link between experiences of self, temporality, relationships with others, and culture (Sarbin, 1986).

Because narrative psychology wished to reinstall the experiencing subject, it operates with a realist epistemology (Crossley, 2000). Thus, it assumes a connection between what a person says or writes and how that person thinks, feels and reflects (ibid.). By applying certain research methods it becomes possible to explore human experience and consciousness. Narrative psychology was originally developed as a way of understanding the psychology of trauma - and the way that people respond to traumatizing events such as the experience of terminal illness (Crossley, 2000b, p. 40). As such, it is intended as a framework for analyzing interview material and is less suited for observations of talk-in-interaction. In relation to this project which utilizes both interviews and observations of interactions, this is an argument for combining positioning theory and narrative psychology. The self-stories of the psychiatric patients and staff in the interviews of the project may provide information about their subjective experiences. Meanwhile, the observations of the naturally occurring talk of the patient-professional interactions may allow me to see more clearly how stories are told, and how selves are created in a collaborative way between participants. Thus, the blending of the theories is guided by the many similarities between them, and at the same time strengthened by the ability of the theories to serve different functions within the project.

From the particular to the institution – institutional ethnography as an analytical strategy

Although positioning theory and narrative psychology provide conceptual tools for understanding interactions and personal experience, both operate with a rather vague concept of “culture” and tell us little about institutions within it. As this project is situated in a specific institutional context,

(modern psychiatry) I will also draw on theories that have institutions as their object of research. My understanding of institutions is specifically inspired by Dorothy Smith's (2002) *institutional ethnography*. Smith (1987) defines institutions as "a complex of relations forming part of the ruling [relations], organized around a distinctive function – education, health care, laws and so on... We might imagine institutions as nodes of knots in the [ruling] relations... coordinating multiple strands of action into a functional complex" (p. 160, quoted in Smith, 2002, p. 43). According to Smith (2002) institutions are unique in that they construct forms of consciousness – knowledge, information, facts, legal rules etc. – that override individuals' perspectives. In institutional ethnography, people's experiences and everyday life in the institutional context are taken as the starting point of the analysis. However, the research process does not end there; the everyday lives of people within an institution are used to map the social relations that are implicit in the organization of their individual experience. The movement of institutional ethnographic research thus goes "from an exploration of the everyday particularities [...] to exploring the generalizing and the generalized relations in which the individual's everyday world is embedded" (ibid., p. 25). Accordingly, this project assumes that by learning from the specific character of the everyday lives of patients and professionals within psychiatry, it becomes possible to explore the institutional orders in which their work contributes and with which it is coordinated.

The language of the institution is seen as central in this process. According to Smith (2002) the language or speech genre of the institutional setting carries institutional organization. The phenomena of language are considered to be coordinators or organizers of people's divergent consciousnesses. Thus, in an interview situation or in a meeting between patients and staff, the institutional organization is not directly visible, but is an underlying determinant of how it is talked, because it is the only way in which it makes sense to talk (ibid., p.44). Also, written texts, such as patient records and official policy documents are considered of key importance in understanding an institution, since they become a standardized component in every setting in which the text is viewed.

In this project I am particularly inspired by the analytic move of institutional ethnography from the particular to the generalized and generalizing. By interviewing patients and staff, observing their actions and analyzing text documents, I will attempt to explore the social relations and dominating discourses that structure the organization of the institution of psychiatry.

7. List of references

Adams, T. (2000). The discursive construction of identity by community psychiatric nurses and family members caring for people with dementia. *Journal of Advanced Nursing*, 32 (4), pp. 791-798

Adams, T. (2001). The conversational and discursive construction of community psychiatric nursing for chronically confused people and their family. *Nursing Inquiry*, 8 (2). Pp. 98-107

Alvesson, M. & Karreman, D. (2000). Varieties of Discourse: On the Study of Organizations through Discourse Analysis. *Human Relations,* vol. 53 no. 9, p. 1125-1149

Avdi, E. (2005). Negotiating a pathological identity in the clinical dialogue: Analysis of a family therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, vol. 78, pp. 493-511

Barker, P. & Stevenson, C. (2000). *The Construction of Power and Authority in Psychiatry*. Oxford: Butterworth –Heinemann.

Benwell, B. & Stokoe, E. (2006). *Discourse and Identity.* Edinburgh: Edinburgh Press

Bowers, L. (2010). How expert nurses communicate with acutely psychotic patients. Mental Health Practice, vol. 13 (7). pp. 24-26

Burr, V. *An introduction to social constructionism*. London: Routledge

Buus, N. (2005). *Communication among mental health nurses: A field study of mental health nursing practices.* Ph.D. thesis, Faculty of Health Sciences, University of Southern Denmark

Crossley, M. (2000). *Introducing Narrative Psychology: Self, trauma and the construction of meaning.* Buckingham: Open University Press

Cutcliffe, J. & Happell, B. (2009). Psychiatry, mental health nurses, and invisible power: Exploring a pertubated relationship within contemporary mental health*. International Journal of Mental Health Nursing*. Vol. 18, pp. 116-125

Danske Regioner (2009). *En psykiatri i verdensklasse. Regionernes visioner for fremtidens psykiatri*. ISBN 978-87-7723-603-7

Davies, B. and Harré, R. (1990), Positioning: The Discursive Production of Selves. Journal *for the Theory of Social Behaviour*, vol. 20, pp. 43–63.

Denzin, N. (2006). *Sociological Methods: A Sourcebook.* Aldine Transaction. (5th edition).

Elliott, R. Fischer, C.T., Rennie, D.L. Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, pp. 215-229

Foucault, M. (1965). *Madness and Civilization: A History of Insanity in the Age of Reason*. USA: Random House

Gubrium, J.F. & Holstein, J.A. (2001). *Institutional Selves – troubled Identities in a Postmodern World.* Oxford University Press

Hamilton, B. & Manias, E. (2006). 'She's manipulative and he's right off': A critical analysis of psychiatric nurses' oral and written language in the acute inpatient setting. *International Journal of Mental Health Nursing*, 15, pp. 84-92

Harré, R. & van Langenhove, L. (1999). (eds.). *Positioning theory*. Oxford: Blackwell

Hayne, Y. (2003). Experiencing psychiatric diagnosis: client's perspectives on being named mentally ill. *Journal of Psychiatric and mental health nursing, 10, pp. 722-729*

Hodge, S. (2005). Participation, discourse and power: a case study in service user involvement. *Critical Social Policy Ltd*, vol. 25, pp. 164-179

Hui, A. & Stickley, T. Mental health policy and mental health service user perspectives on involvement: a discourse analysis. *Journal of Advanced Nursing*, Vol. 59 (4),pp. 416 – 426

Jonsdottir H., Litchfield M. & Pharris M. (2004) The relational core of nursing practice as partnership. *Journal of Advanced Nursing*, vol. 47, pp. 241–248.

Kvale, S. & Brinkmann, S. Interview. (2009). Learning the Craft of Qualitative Research Interviewing. (2nd ed.). London: Sage

Middleton, L. & Uys, L. (2008). A social constructionist analysis of talk in episodes of psychiatric student nurses conversations with clients in community clinics. *Journal of Advanced Nursing* 65(3), 576–586

Miller, P. & Rose, N. (ed.) (1986). *The Power of Psychiatry.* Cambridge: Polity Press

Region Sjælland Psykiatri (2010a). *Brugerstyret Psykiatri. Skitse og ideer til lokal implementering.* Psykiatrien Region Sjælland.

Region Sjælland Psykiatri (2010b). *Virksomhedsplan 2010*. Psykiatrien Region Sjælland

Region Sjælland Psykiatri (2008). *Psykiatriplan for Region Sjælland. Mennesker og muligheder – psykiatri med relationer.* Psykiatrien Region Sjælland.

Roberts, M. (2009). Service user involvement and the restrictive sense of psychiatric categories: the challenge facing mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 2010, **17**, 289–294

Robertson, M., Paterson, B., Lauder, B., Fenton, R. & Gavin, J. (2010). Accounting for Accountability: A Discourse Analysis of Psychiatric Nurses' Experience of a Patient Suicide*. The Open Nursing Journal*, vol. 4, pp. 1-8

Rose, D. (2003). ; Partnership, co-ordination of care and the place of user Involvement. *Journal of Mental Health (2003) 12, 1, 59–70*

Roter, D.L. & Hall, J.A. (2006). *Doctors Talking with Patients/Patients talking with Doctors. Improving Communication in Medical Visits.* 2nd ed. London: Paeger

Sarbin, T (1986). Narrative Psychology: the storied nature of human conduct. New York: Praeger

Schegloff, E. (1997). Whose text? Whose Context? *Discourse & Society,* vol. 8 (2). pp. 165-187

Smith, D. (2002) Institutional Ethnography. In: May, T. (ed.) Qualitative Research in Action. London: Sage

Stevens, P. & Harper, D.J. (2007). Professional accounts of electroconvulsive therapy: A discourse analysis. *Social Science & Medicine*, vol. 64, pp. 1475-1486

Thompson, (1984). The Invisible Helping Hand: The Role of Communication in the Health and Social Service Professions. *Communication Quarterly*, Vol. 32 (2), pp. 148-163

Warne, T. & Stark, S. (2004;). Service users, metaphors and teamworking in mental health. *Journal of Psychiatric and Mental Health Nursing,* 2004, vol. 11, pp. 654–661