

**The Therapeutic Alliance in  
Mental Health Services:  
A Politico-Critical Analysis of  
Knowledge and Power**

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## ABSTRACT

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The therapeutic alliance in mental health services has been researched extensively especially with regards to care provider and care receiver characteristics that may affect therapeutic outcomes. In the literature, it seems to be commonly assumed that the alliance has an inherent power imbalance in favour of the professional. Beyond this assumption, research on the knowledge-power balance in the alliance is limited.

The aim of the study was to explore the dominant discourses related to the balance of knowledge and power in the therapeutic alliance in mental health services. An additional interest was the role that these identified discourses may play in the positions occupied by care providers and care receivers in the alliance. A final objective was the identification of care provider and care receiver knowledge needs in relation to the management of the knowledge-power balance in the alliance in a manner that may enhance therapeutic effects.

Ten semi-structured interviews were conducted involving individuals who were receiving psychiatric care in the inpatient setting at the state psychiatric hospital in Malta. The second phase of this study involved the analysis of the Medical and Nursing records that pertained to the ten participants who had been interviewed. A Foucauldian Discourse Analysis framework was used to guide the study and Foucault's concepts of knowledge and power served as the theoretical underpinning of the study.

The care receivers' contribution to the discourses pertaining to the knowledge-power balance in the alliance led to the identification of four different types of alliances with distinguishable knowledge-power characteristics. Three discursive themes were identified from the Medical and Nursing records and these were perceived as being complementary to the findings that emerged from the care receivers' interviews. Finally information related to the potential knowledge required by care receivers and care providers in order to manage the knowledge-power balance in an effective manner was extracted from the data and presented together with recommendations.

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## **ABBREVIATIONS AND ACRONYMS**

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<b>ADHD</b>	Attention Deficit Hyperactivity Disorder
<b>APA</b>	American Psychiatric Association
<b>CBT</b>	Cognitive Behavioural Therapy
<b>CP</b>	Care Provider
<b>CR</b>	Care Receiver
<b>DSM</b>	Diagnostic and Statistical Manual
<b>ICD</b>	International Classification of Diseases
<b>IQ</b>	Intelligence Quotient
<b>MI</b>	Multiple Intelligences
<b>MR</b>	Medical Record
<b>NICE</b>	National Institute for Health and Care Excellence
<b>NR</b>	Nursing Record
<b>p. / pp.</b>	Page/s
<b>Para.</b>	Paragraph
<b>Sec.</b>	Section
<b>UK</b>	United Kingdom
<b>USSR</b>	Union of Soviet Socialist Republics



## ACKNOWLEDGMENTS

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I would like to express my deepest gratitude to the care receivers who participated in my study. I owe them a lot, mostly with regards to their ability to keep me grounded when I was deeply immersed in theoretical concepts. They were a very important constant reminder that at the bottom of it all, I am dealing with precious human lives and with individuals who, like myself, have only one lifetime to make the best out of the biopsychosocial cocktail that life has delivered to them. I would also like to thank them for being the catalyst to my interest which led to the study as well as for the time and effort that they dedicated to engage in the study.

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It took endless practical and inspirational support by my loved ones in order for me to reach this target. Thank you for putting up with my periodic disappearances and for allowing me to drag my work into every event and situation. You are big stars who always lit the way when it got too dark.

## **DECLARATION**

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I declare that I have conducted this study and that this thesis is entirely my own work. When the work of others features in the text, this is indicated by referring to the original source. This thesis has not been submitted to any other academic body in fulfilment of a degree and it has not been published.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

## *Chapter 1*

# INTRODUCTION

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## **1.1 Introduction**

The therapeutic working alliance in mental health services is one of the most important tools used in addressing mental health challenges and facilitating recovery (Castonguay, Constantino & Holtforth, 2006; Johansson & Eklund, 2003). Research around this area seems to focus on the theoretical structure of the alliance and on the impact of care provider and care receiver personal characteristics on the nature of the alliance. Although the dominant discourses that have affected the evolution of psychiatry have been explored, it seems as if this research may have not been extensively applied to the therapeutic alliance in practice. In this thesis, it is hypothesised that the identification and exploration of dominant discourses in mental health may shed light on how they influence the behaviour of the care provider and care receiver in the therapeutic alliance. Furthermore, this process may illuminate the types of knowledge that care providers and care receivers need in order to steer the knowledge-power balance in a manner that facilitates a care receiver-friendly therapeutic destination and plots the best route to it.

## **1.2 Reflections on the personal rationale for the study**

As a way of explaining my personal rationale for the study, I would like to present a brief introduction of myself. During the past ten years, I have been involved in mental health and psychiatry. I spent the first six years working as a nurse in a psychiatric setting, first in an acute ward and then as a team leader in a psychiatric outreach team. Four years ago, I left the clinical setting and took on a lecturing role in mental health nursing at the University of Malta. However, I still maintain contact with the clinical setting, mostly through student-related responsibilities. During this decade, I have directly experienced many positive changes in mental health services, especially in my country. This was particularly brought about by the drive to downsize the inpatient setting whilst optimising community services. On a parallel level, specialist psychiatric training was enhanced especially with regards to doctors

and nurses who work in these services. Despite these clear advances, I often have doubts about the depth of these changes in relation to patient empowerment, autonomy and self-determination in state psychiatric care. On the basis of my experience in the local clinical setting, I feel that it is indeed soul lifting to observe professionals who provide care receivers with treatment options and structured care in the local setting. Contrastingly, to me, it is painful and alarming to realise that in some of the areas, care receivers are still experiencing sub-standard care especially due to limited treatment options, a very limited amount of structured therapeutic activities and worst of all, a lack of basic respect. In brief, these were the main factors which prompted me to explore that which I regard as being the core of mental health services – the therapeutic alliance. I wanted to approach this area by specifically exploring the dominant discourses and other factors that may affect the management of the knowledge-power balance in the alliance. I believe that this may help me to understand why things are as they are - the *status quo* - the reason why the knowledge-power nexus may be quite balanced in some therapeutic alliances but so skewed in others. Moreover, as a consequence of enhancing my understanding in this area, I also wished to develop a better perspective of the knowledge or training needs that may be required by care providers and care receivers. I believe that as a lecturer, I am in a position which can help me to bring about change especially due to my input in the guidance of students, who are the future psychiatric care providers. Furthermore, I feel that my clinical and academic experiences give me the opportunity to focus on pragmatism especially on the application of academic knowledge to actual clinical practice. One of my inspirational figures, Dr. Shaun Grech, who is a researcher on issues related to disability and poverty, may have captured the essence of my vision, when he said:

I do what I do because there are already too many sedentary academics who make a career out of detachment and talking about the reality ‘out there’ from the safe and sometimes ever so arrogant distance of their comfortable, Western offices. There are also too many do-gooders trying to save the world by imposing their own values, beliefs and ways, without listening, without learning, without research...this is the little contribution I want to give in this life (Grech, 2012 a,b).

At this point, I would like to state that despite the measures that I took to increase the trustworthiness of this study (as described in Chapter 3), I was not free from bias. I have strong feelings about the area of study especially when addressing issues related to care receiver respect and self-determination. However, whilst acknowledging this bias, I also chose to perceive it as a strength because it may have allowed me to relate to my participants and to understand the findings in a comprehensive manner - this may have been more challenging had I been a complete outsider.

### **1.3 Background**

A glance at the literature dedicated to the therapeutic alliance reveals that the concept has been practically raised to deity status. This is due to the fact that numerous studies have routinely revealed that the quality of the working alliance between a care provider and a care receiver is directly linked to treatment outcomes and is thus a highly important factor in an individual's recovery journey (Gilburt, Rose & Slade, 2008, p.1).

Undeniably, the underlying current beneath this concept has been linked to the latent issues of knowledge and power within the alliance and this has been subsequently explored by several theorists such as Brown (2003, p.231), Foucault (1995, p.214) and Flaskas and Humphreys (1993, p.35). These issues have molded psychiatric practice and may have been influential in the move from oppressive psychiatry that featured an *all knowing* professional to enhanced mental health services that regard the patient and the professional as both being *partial knowers* (Brown, 2007, p.4). In mental health, recovery is sometimes metaphorically described as a journey (Barker & Buchanan-Parker, 2005). In a continuation to this metaphor, a road mapping analogy shows both entities within the therapeutic alliance attempting to manage the knowledge-power balance in order to collaboratively identify a destination (this being the ultimate goal of the alliance) and map the road to it (that is, by forming a care plan). Apart from the personal attributes and characteristics inherent in the care giver and care receiver, Hinshelwood (2001) suggested that psychiatry and by default, the therapeutic alliance, have been predominantly influenced by dominant discourses on the subject (p.286). This implies that external ideas about the alliance

in mental health services may affect the nature of the relationship between the care provider and receiver. Theorists such as Foucault (1979/1995) paid homage to this subject by depicting how ideological beliefs pertaining to a specific field form bodies of formal knowledge (*episteme*), be it erroneous or accurate (p.218). This may give rise to power relations since subjects who dissent from this knowledge may be regarded as deviant and even punished. As an example, in his postmodern view of the social construction of mental illness, Walker (2006) implied that dominant discourses related to mental illness may have been majorly responsible for the barbaric historic psychiatric practices which darken the history of this discipline (p.31).

The main interest in my study was to identify the discourses which affect modern-day psychiatry and their role in the knowledge-power balance management in the contemporary therapeutic alliance. Current research in this area focuses mostly on care provider and care receiver personal characteristics and not specifically on dominant discourses. Thus, my study attempted to address this gap and to add an additional piece to the rich knowledge base that can be found in relation to this area.

There is research which indicates that factors such as care provider empathy, genuineness and other factors may be beneficial to therapeutic outcomes related to the alliance. To a much lesser extent, care receivers' characteristics have also been explored although this part of the literature seems to center on pathological factors that may have implications on the alliance. This may point towards an observation made by Zur (2009) who noted that very limited research has been carried out beyond the seemingly accepted view of an omnipotent professional (who has to use skills to steer the alliance) and a helpless (ill) patient. According to him, a fundamental mistake is being made when one assumes that a therapeutic alliance is inherently and inevitably characterized by a power imbalance (p.161).

Year 2013 marked the 40<sup>th</sup> anniversary of *Being Sane in Insane Places* - a study carried out by Rosenhan (1973) which featured a group of 'normal' people who managed to gain admission into a psychiatric hospital in order to go through the experience of being a patient in such a setting. The most prominent finding was related to the fact that the pseudopatients were diagnosed as suffering from

schizophrenia and discharged only after an average period of 19 days (with the label of schizophrenia in remission) even though their pseudosymptoms had disappeared immediately following admission. These findings were perceived as placing serious doubts on the validity of psychiatric diagnosis. The study by Rosenhan had an additional objective which was that of exploring the interactions between the pseudopatients and the staff. In this regard, the pseudopatients noted the way that they were treated by different staff members by recording activities such as eye contact and meaningful interactions. The findings implied a power differential that was clearly in favour of the professionals in a way that may have indicated abuse of professional power.

Forty years later, the field of mental health and psychiatry is still characterized by debates that range from issues as basic as whether the field actually exists to the various perceptions regarding its evidence base and that of the treatment on offer. Rosenhan's findings served as the fuel for my curiosity with regards to the nexus of knowledge and power in the therapeutic alliance. Thus my interest lay in exploring the different ways that the therapeutic alliance is spoken about and how spoken words and perceptions may affect the actions of the care providers and receivers within the alliance. Foucault's work helped to shape the queries that I had in a way that allows a structured exploration by means of Foucauldian Discourse Analysis.

As a result, the main research question guiding this study was:

**What is the nature of the combination of knowledge and power in therapeutic alliances in a mental health in-patient setting in Malta?**

This was accompanied by two sub-questions, namely:

**What role do dominant discourses play in the positions occupied by care providers and care receivers in therapeutic alliances in a mental health in-patient setting in Malta?**

**What type of knowledge is required by care providers and care receivers for power to be managed in a manner that may enhance therapeutic effects in this setting?**

## **1.4 The setting of the study**

The study was carried out in Malta, which is one of the main three islands that make up the Maltese archipelago. The islands are situated in the Mediterranean Sea between Sicily and Libya. The main island, Malta, has a population of 417,000 and an area of 316 square kilometres (Government of Malta, 2013, sec.2). Having been governed by various nationalities, the Maltese culture is made up of a rich mixture of styles and traditions. The official languages are Maltese and English and the predominant religion is Roman Catholic. The archipelago has been a European Union member state since 2004. Malta has a free public healthcare system which includes one main general hospital, a smaller general hospital on the sister island of Gozo and separate hospitals dedicated to oncology, geriatric care, rehabilitation and psychiatry. There is also a primary healthcare system and a number of private clinics and hospitals that offer a variety of services (Government of Malta, 2013, sec.1-8).

The setting of this study was the state psychiatric hospital in Malta. Although a range of private psychiatric services are available, the state psychiatric service is the only one to offer a range of specialist services and inpatient facilities on the island. Prior to the construction of this hospital, mental health care in Malta was targeted at containment and restraint rather than treatment (Mental Health Services, 2011, p.2). In his review about mental health care in Malta, Savona Ventura (2004) described how between 1574 and 1835, people who suffered from mental distress were kept in a number of places which were mostly located in the capital city of the island, Valletta and its neighbouring town, Floriana. Within these different places, patients were kept in inhumane conditions, most often chained to walls, exposed to physical abuse and left in their own dirt until they died.

In 1835, a knight of the Order of St.John, Bali Fra Fabrizio Franconi donated his residence for use as an asylum. The residence, named Villa Franconi, was characterised by the same poor living conditions that had been previously found in the other psychiatry settings. However, the appointment of a new visiting physician, Dr. T. Chetcuti, was influential in an improvement of conditions. This physician who



remained known as the ‘father of psychiatry in Malta’ succeeded in releasing patients from their chains, limiting the use of seclusion and began using the straight jacket only in those cases where patients became irritable and dangerous. He also attempted to stop the carers (known as attendants) from using the term ‘mad’, maltreating the patients, swearing and stealing food or other supplies. By increasing the number of attendants, he tried to ensure better supervision of the patients in the asylum. By 1859, the place was very overcrowded and the overall condition had deteriorated to such an extent that it was decided to build a new mental hospital as an attempt to improve care. This led to the construction of the hospital that is still in use today.

This institution was opened in 1861 to accommodate 248 patients from Villa Franconi who were transferred during the night to the new hospital. To this very day, the term ‘Ta’ Frankuni’ is still used amongst lay people to refer to this hospital even though the official name of the hospital is Mount Carmel Hospital. Although this building already had structural problems and obsolete systems, the ordered atmosphere and organisation impressed foreign visitors at the time of its opening. Unfortunately the attendants continued to constantly create problems because of lack of discipline, knowledge and respect – most of them were orphan girls who were forced to work in the asylum and they went about in bare feet and dressed in tatters.

It was at the beginning of the last century that the nursing situation regarding educational standards and number of staff began to improve. In 1995, the first community services were introduced and in 2008, a plan was made to offer community psychiatric services all over the island. Nowadays these include an Outreach Team and Crisis Intervention Service, Primary and Secondary Teams mostly situated in primary care health units, psychiatric day centres and hostels. The state mental health service includes inpatient facilities and community services all of which fall underneath the responsibility of one management structure. All services are provided by multidisciplinary teams mostly led by a consultant psychiatrist (Mental Health Services, 2011, p.24). The inpatient setting is mainly situated in the psychiatric hospital (with a capacity of 581 beds) with a smaller unit on the sister island of Gozo. Services cater for general psychiatry and specialist areas such as dual diagnosis, forensic psychiatry, learning disability, rehabilitation,

psychogeriatrics and paediatric/adolescent psychiatry. Liaison psychiatry and joint clinics such as Neuropsychiatry and Perinatal Psychiatric clinics are found at the general hospital (Mater Dei Hospital). Outpatient facilities are also provided at the general hospital and within the primary healthcare centres scattered around the island. The private sector has also been involved in offering a number of community services such as hostels and employment support for individuals with mental health difficulties.

Since 1995, the local political agenda has been giving more prominence to mental health. Service provision is based on *The National Policy on Mental Health Services* which was published in 1995. This policy focuses on promotion and prevention as well as treatment and rehabilitation. The *National Health Systems Strategy for Malta 2014 – 2020* listed mental health as one of the main target area for the allocation of resources (Ministry for Health, 2014, p. 39). At the moment, there is an ongoing transition from the old *Mental Health Act* enacted in 1976 to a new one. The emphasis of the new act is the provision of holistic care and enhanced service-user autonomy. Although this is indeed an important step for mental health care in Malta, I feel that there are a number of cracks beneath the smooth façade that is being projected. For instance, a survey carried out by the Maltese Association of Psychiatric Nurses (2013) showed that only 4% of nurses stated that they have adequate information about the new law, with 80% of them believing that they have been poorly informed about it. My concern is that these nurses are the frontline professionals who have to implement the act in actual practice and so it is worrying that they may not really know what they need to be implementing. On a similar note, it seems as if though several consultations groups were carried out in the construction of the new Mental Health Act, only two service users contributed to the process (R.Xerri, personal communication, December 9, 2014). It seems to me then as if, with regards to service users: we have been doing things **for** them and **about** them but perhaps it is high time that we start doing things **with** them.

On a personal note, I feel that in Malta, the mental health area, especially the psychiatric hospital that features in the historical description that I have provided and that is still in use today, is viewed as somewhat inferior to the rest of the health-

related areas and institutions on the island. Thus for example, it is an open undocumented secret that a good number of individuals who work in psychiatry in Malta are not there due to their passionate interest in the subject but due to the fact that they could not get into other branches or have been involuntarily transferred from other areas for a variety of reasons. I believe that this may pose difficulties related to the initial level of motivation that they may then have when it comes to offering good quality care. However, it is good to note that some of these individuals eventually develop an interest in the area and remain there, even seeking further specialised education.

Although there is no empirical evidence to confirm this, I feel as if the image of mental health in Malta has improved over the last fifteen years. Whereas before the area had been regarded as mystic and somewhat dark and taboo-like, now it seems to be portrayed as a group of disorders, not unlike medical disorders, that mostly belongs to the poor and uneducated – the lower class in society. Perhaps this change has been brought about by better representation of mental health/distress on local media which seems to be currently more neutral in the reporting of events especially by reporting both positive and negative events (rather than negative ones only) when it comes to mental health. The commitment towards the professional development of professionals who work in the state mental health services has also shifted the image to a more academic, professional and clinical one where now it is clearer that individuals who are suffering from mental distress need specific professional help rather than punishment, scorn or custodial care. This is a great step for an island which until the past decade, was considered as quite conservatist and practically dominated by the Catholic Church which worked in close partnership with the political and education leads of the state. This was a time when the main teachings of the church were aimed at controlling individuals by instilling in them a deep fear of an afterlife in hell if they stray from the moral teachings of the Roman Catholic religion. This implied that a number of areas such as sex (especially extramarital and homosexuality issues) and non-mainstream ideas (such as the practice of spirituality in a non-religious way) were moral sins that had to be confessed to a priest who would then recommend a process of penitence. Mental distress was viewed by the church as a mixture of pathological ailments that had to be corrected by prayer and

medical help. I do not remember a time when the church perceived mental distress as being a direct punishment for immoral behaviour. However, I do remember being subjected to Sunday sermons where the priest actively encouraged individuals who had mental distress to throw away psychiatric drugs since their only salvation lies in having a better relationship with the Heavenly Father. To this day, there still seems to be a belief that praying (using the Roman Catholic technique) may be the magic bullet to address all concerns including mental distress. Whereas this seems to instil hope in some people, it can also have negative consequences especially for non-believers (who may still feel cultural pressure to conform to the mainstream religion) or even for believers (who may potentially benefit from alternative options but fear to do so because of religious teachings). Saying this, I cannot negate the Maltese church's immense effort to offer material resources and comfort to people in need (including those suffering from mental distress) – oftentimes, this served as a safe haven for these individuals especially during a time when state community psychiatric services had not yet been introduced. Lately Malta has undergone many interesting changes such as becoming an EU member state, introducing the legal right to apply for divorce (introduced following a national referendum) and the legal right for same-sex marriages. These were giant steps which left the island partially divided and some institutions (such as the church) with a feeling of instability and unsettlement. It is no wonder since behaviours that have been considered a sin (and abnormal behaviour) for so long are now legally accepted by the state. I feel that these are all changes that have the potential to shift that which Foucault referred to as the *episteme* - the accepted manner of obtaining and arranging knowledge in a given era (Fendler, 2010, p.39). I also feel that it is an interesting era for one to be working in the mental health setting in my country since these changes in the cultural system will inevitably affect how things are done in many aspects of life including the perception and management of normality and abnormality.

## **1.5 Method**

The first phase of the study involved the interviewing of ten individuals who were receiving psychiatric/ mental health care in the inpatient setting at the psychiatric hospital. The focus of the interview was to listen to each individual's account of

his/her experience of knowledge and power in the relationships that s/he has with the different members in the multidisciplinary team. The second phase of this study involved the analysis of the medical and nursing records that pertained to the participants in Phase 1. A Foucauldian Discourse Analysis framework was used to guide the study in both phases.

## **1.6 Conclusion**

The aim of this study was to gain further understanding of the dominant discourses pertaining to the balance of knowledge and power between the care provider and care receiver as well as the role that these discourses play in the therapeutic alliance. Furthermore, this exploration helped to identify the type of knowledge that may be required by both parties in order for power to be managed in a manner that enhances therapeutic effects. In addition to addressing an area that is characterized by a local dearth of research, I feel that this study has also given a voice to some care receivers as they shared their experience in this hospital in Malta.

Following this introductory chapter, the next chapter involves a review and appraisal of the research and theoretical work that can be found in the literature as well as a contemporary view of the subject. It also facilitates the identification of research gaps in relation to the potential contribution of this study. Areas included are: a review of the concept of knowledge, an exploration of some of the perceptions on mental health and psychiatry and a culmination in the discussion of the therapeutic alliance in mental health. Chapter 3 consists of a description of the research method followed. This includes the justification of the method in question followed by presenting the actual blueprint of the study, in other terms, the actual design that guided the process. The findings of the study as well as the process of data analysis are presented in Chapter 4. The analytical discussion in Chapter 5 presents an attempt at interpreting these findings and their relation and relevance to the existing literature as well as to the local situation. Recommendations are also provided in view of the findings that emerged. The final chapter serves as a last opportunity to revisit the research questions and to reflect on how these have been addressed by the information generated from the study. Additionally, the final part includes the recognition of the strengths and limitations of the study as well as final thoughts and

reflections. During this thesis, the terms *patient*, *client*, *service user* and *care receiver* have been used interchangeably. The same applies for the terms *professional*, *practitioner* and *care provider*. My preferred terms are *care provider* and *care receiver* as to me these represent neutrality and equality between the two entities. However, the terms *patient* and *professional* were the ones that featured the most during the interviews with the care receivers and in the medical/nursing records that were analysed. In faithfulness to the data sources, I have used the same terms that were originally used by the participants in the excerpts that I have included in this thesis.

## *Chapter 2*

# LITERATURE REVIEW

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## **2.1 Introduction**

The area of interest in this thesis is the therapeutic alliance and its inherent balance of knowledge and power. It may seem controversial that only one part of this review (Part 3) has been wholly and specifically dedicated to an overview of the alliance. This is not through sheer carelessness by neglecting to avoid paying homage to the very core subject of this study. It is rather attributed to my belief that this alliance, which refers to the bond that is formed between a service provider and receiver in order to reach therapeutic goals, is not a standalone phenomenon. Here it is being contended that the alliance does not start with a *rendezvous* and end when the set goals are met. On the contrary, my postulation is that even before the care provider and receiver become acquainted, a number of parameters for their alliance have already been invariably set. This is partly by virtue of the role of discourse in the mental health field – not necessarily specific discourse on the therapeutic alliance but on the wider concept of mental health and its related services.

This literature review is not about the provision of concrete answers or the construction of a linear development. It is also not about addressing the immediate front line characteristics of the therapeutic alliance – these have been already addressed by a plethora of research which shall be referred to in the final part of the review. Instead, as based on a Foucauldian approach, the aim is to explore some of the historical factors pertaining to knowledge and power issues in society and mental health and their influence on the perceived truth. It is a tribute to the discourse that characterised the evolution of the therapeutic alliance through the passing of the years. Finally, it concerns an epistemological process through the ongoing investigation of the nature and scope of knowledge in society and in the mental health world. As explained in a latter part of this review, I do not profess to be completely free from any bias. Thus, I acknowledge that despite my effort to make this review as exhaustive and as comprehensive as possible, the selection of topics to

explore has been invariably influenced by my own subjectivity. In an additional confession, a further intention of undertaking this review was that of challenging my own assumptions which knowingly or unknowingly influence my perceptions and decisions. This characterises a process of growth – a learning curve that is hoped to extend till the conclusion of this research study, and then move beyond. In Foucault's terms: "I don't feel that it is necessary to know exactly what I am. The main interest in life and work is to become someone else that you were not in the beginning" (Foucault, 1982, p.9).

This chapter has been divided into three parts. As an introduction to each part, I have written a short fictitious story that is intended to set the scene as well as to communicate my thoughts, feelings and position in the debates within that specific part of the review. The first part has been dedicated to a broad examination of the concept of *knowledge* and its relation to reality, truth and power. My decision to explore this concept has been based on one of the aims of this study, which involves the identification of the type of knowledge required by care providers and receivers for power to be managed in a manner that enhances therapeutic effects.

This leads to the subsequent part which involves a detailed critical investigation of some of the discourses in mental health – it is not identical to, but yet not unlike Foucault's *archaeology*, which generally refers to the philosophical evaluation of the methodological assumptions in the thinking of different cultures, ages and historical periods (Foucault, 1972, p.131). This section has been included in the review in an attempt to generate background information related to the other aims of this study, namely the identification and role of the dominant discursive themes pertaining to the balance of knowledge and power in the therapeutic alliance.

The concluding part of the literature review has been devoted to the therapeutic alliance itself, in relation to its origins, principal characteristics and the issues of knowledge and power that are intertwined in it. The aim of this final part is to place the discursive object (the therapeutic alliance) within the backdrop set by the first two parts of this review.



## 2.2 Knowledge

### 2.2.1 Introduction

*In the stillness of the night, she could not stop the torrent of thoughts as she gazed at the twinkling lights scattered across the dark sky. Was it possible that some of those tiny twinkling stars were inhabited by other creatures who, at that very moment, could be similarly viewing the Earth as a speck...one of many? It was a thought that instilled an uncomfortable feeling in her as she wondered about the possibility of another life, another reality, way up above the Earth, as perceived and experienced by another life form akin to humans. But then what is reality? And what makes it true? She thought about the knowledge that she had acquired in her school days about various facts, phenomena, mathematical problems and common sense stuff. She had always taken that as being true steadfast knowledge but now she could not help thinking about the possibility that that knowledge could have been relative rather than real. The shrill of the pill reminder dragged her unceremoniously from her dream world as her gaze shifted upon the two tiny pink pills on the nearby table. They would control her thinking – the nurse had called it ‘flight of ideas’. Sometimes she was told that she suffered from delusions too. But there again, she wondered, on what basis was this knowledge founded? Was it real or was it simply relative? Her thoughts drifted away as she reached for the pills and waited patiently until the loud thoughts in her head were converted to mere whispers.*

Author’s own

In this thesis, knowledge is one of the key actors, in particular by virtue of its link to power within the therapeutic alliance. Furthermore, one of the aims of my study was to explore the knowledge required by care providers and receivers to manage the knowledge-power balance within the therapeutic alliance in an effective manner. Thus, I feel that it would be fruitful to start this review of the literature by exploring the concept of knowledge. On the basis of a philosophical approach, I feel that this can be followed more effectively if I attempt to question pre-existing notions about knowledge. This relates to all those syntheses, traditions and notions that may have been previously accepted as a definite fact or as the ultimate truth. This does not

refer to a process of metaphorically re-inventing the whole wheel – but perhaps exploring how ‘the wheel’ was invented and the gaps prior to and after its invention.

Foucault (1981) contended that:

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 (p.456).

In this manner, the actual question of how much one knows and the actual doubting of the nature of knowledge is hoped to help with the progression into a discernment of the concept of knowledge.

This part of the review has been divided into three sections. The first section concerns an epistemological exploration of the concept of knowledge. The word *epistemology* originated from the Greek language: *episteme* = knowledge and *logos* = study (Miller, 2010, para.1). Thus, epistemology refers to the study of knowledge in terms of its nature, acquisition and measurement. The second section explores the ontological perspective. *Ontology* is another term that has Greek roots: *ontos* = being and *logos* = study, thereby referring to the study of being and the reality base of knowledge (Truncellito, 2007, sec.1). The final section in Part 1 of this literature review examines the link between knowledge, power and truth with specific reference to the ideas of Michel Foucault, whose philosophy underlies this research study.

### **2.2.2 The concept of knowledge – an epistemological perspective**

Epistemological enquiries as to the nature of knowledge are described by Heterington (2012) as “...a history of theses and theories; but no less of questions, concepts, distinctions, syntheses, and taxonomies” (p.1).

This part of the review presents an overview of some of the contentions that have been made about the nature of knowledge and its constituents. As a starting point, we may reflect upon the different kinds of knowledge that have been identified and

presented in the literature. Primarily, the awareness that knowledge can be explicit and attributed to known facts, such as knowing that a week consists of seven days, has led to categorising this particular form under *knowledge that*, as elaborately described in the works of Ryle (1949, p.32). One particular epistemological stance argued by Polanyi (1958) centred on the distinction between *knowledge what* and another form of knowledge that deals with *knowing how*. This is also termed *tacit knowledge* (p.58). A typical example of the latter would be the knowledge pertaining to driving a car or knowing how to arrive at a set destination. A fourth category of knowledge was identified by the logician Bertrand Russell (1959/2008) as *knowledge by acquaintance* which involves a subject being in direct contact with a fact, such as knowing that one is in pain because of the direct contact with the sensation of pain (p.30). This is suggestive of knowledge that is obtained by the act of experiencing. Still, Russell (1959/2008) argued that another form of knowledge – *knowledge by description*, may also exist and allows an individual to have knowledge about that which has been described to him/her even if it has not been directly experienced by the same individual (p.31).

In epistemology, it seems as if one of the basic questions to be answered is if there is such a concept as true or false knowledge and if so, how to distinguish between the two. This path has been followed by key figures in history as outlined by Louis Pojman's comprehensive works in his contemporary account (Pojman, 2002). On the existence of true knowledge, Schafer (2013) described how "the idea that a belief can count as knowledge only if its truth is not merely a happy accident, goes back at least to Plato" (p.1).

Similarly, in his paper titled *Unreliable Knowledge*, Turri (2013) explored some of the prominent historical epistemological debates evolving around the complex nature of knowledge in relation to truth and reliability. On reviewing modern works such as those by Pojman and Turri as well as older ones dating to Socrates and Plato, it seems as if there is a pattern: basic theories of knowledge have attempted to identify static boundaries around the concept of knowledge, by defining it in an absolute, rigid and permanent manner. Conversely, later theories about knowledge recognized its relativity to different situations, its various facets as well as its ongoing change

and evolution. The whole trend seemed to move from a static, passive view of knowledge towards a more adaptive and dynamic one. However, Schafer (2013) contested this observed pattern that I have mentioned by noting that “a good deal of the contemporary discussion of these issues proceeds as if there is a single more or less unified, variety of accidental truth” (p.2). This may imply that in Schafer’s view, modern philosophical discussions about knowledge may still be characterised by the tendency to move towards a unified rigid view of the constituents of knowledge. Perhaps the following journey through some of the works in this area may shed more light on these debates.

In *Theaetetus*, Plato (c360 B.C./1997) presented one of the first important explorations of knowledge when he argued that a statement could be considered as knowledge, if it fulfils the criteria of being *justified*, *true* and *believed*. In his attempt to define knowledge, *Theaetetus*, a young man who featured in this dialogue along with Socrates, asserted that one *knows* when one believes that something is *true*. Socrates questioned this statement by picturing a scenario where a lawyer persuades the jury that a person is innocent. In this case, the jury believe (or know) that the person is innocent (the perceived truth) even if they have been convinced by dishonest means. This led *Theaetetus* to conclude that knowledge is a true belief that must be accompanied by a third condition, that of justification:

*Theaetetus*: Oh, yes, Socrates, that’s just what I once heard a man say; I had forgotten but it is now coming back to me. He said that it is true judgment with an account that is knowledge; true judgment without an account falls outside of knowledge (Plato, c360 B.C./1997, p.223).

However, Socrates rejected this definition by concluding that:

And it is surely just silly to tell us, when we are trying to discover what knowledge is, that it is correct judgment accompanied by knowledge, whether of differentness or of anything else? And so, *Theaetetus*, knowledge is neither perception nor true judgment, nor an account added to true judgment (Plato, c360 B.C./1997, p.233).

However, as Appaih (2003) noted, the justified-true-belief remains a central philosophical claim of the western tradition (p.41). This view, although still popular in nature, is not totally endorsed and it is often criticized as being insufficient in

addressing the true flexible nature of knowledge. One of the most controversial critical arguments was compiled by Edmund Gettier, who with the introduction of *Gettier problems* described situations in which a belief may be justified and true but may still not be considered as actual knowledge (Gettier, 1963). Gettier (1963) based his case on counterexamples of the justified-true-belief contention. For instance, in his first case, the author described a situation in which a man, Smith, applied for a job but believed that another individual, Jones, would be getting the job. Smith had a justified belief that Jones had 10 coins in his pocket and so he concluded the man who would get the job, had 10 coins in his pocket. It so happened that Jones did not get the job and that unknowingly, Smith had 10 coins in his pocket too. So although Smith's belief that the man who would get the job had 10 coins in his pocket was justified and true, it was in fact not knowledge (p.123).

In Greek philosophy, reference was often made to a process of *anamnesis*, meaning, the doctrine of recollection - this refers to an individual being born with a pre-loaded source of innate knowledge that can be recalled or remembered by overcoming the physical body and following a process of discernment, often under the guidance of an interrogator (Treanor, 2001, p.313). This doctrine implies that knowledge is a process of developing ideas that are buried within each being and thus, there is no notion such as learning new information, as this data is simply being recalled or remembered rather than generated. In *Metaphysics*, one of Plato's students, Aristotle, famously disagreed with his mentor on most concepts and criticized the abstract picture of the world as portrayed by Plato. He essentially believed that knowledge was acquired through detailed observation and the classification of phenomena. This rendered the acquisition of knowledge as a purely empirical process, in which experience and the use of our senses serve as the primary source:

All men naturally desire knowledge. An indication of this is our esteem for the senses; for apart from their use we esteem them for their own sake, and most of all the sense of sight. The reason of this is that of all the senses sight best helps us to know things, and reveals many distinctions (Aristotle c384–322 B.C. / 1989, sec. 980a).

Essentially, Greek philosophy was concerned with certainty; how could one be certain that knowledge is not simply an illusion? Aristotle attempted to resolve this

doubt by classifying different types of knowledge into categories, this being especially captured in *Book VI of the Nicomachean Ethics* (Aristotle c350 B.C./1999). Primarily, he addressed that form of knowledge which is characterized by facts and a high degree of certainty, such as mathematical equations. This class of knowledge is shaped by precise rules and explanations. Conversely, the other type of knowledge identified by Aristotle is the kind that cannot be captured and explained in an easily predictable way. Examples of the latter category of knowledge may be related to the fields of human behaviour, psychology and ethics. In *Metaphysics*, the philosopher elaborated further by introducing a thought provoking tangent - the need for evidence in determining the validity of knowledge. He went on to describe how this evidence may be produced in the scientific world where science can be practical (ethics and politics), poetical (art) or theoretical (mathematics, physics and metaphysics) (Aristotle c384–322 B.C./1989, sec. 1025b25). In a paper about knowledge management, Richter (2010) probed the Aristotelian concept of evidence that is brought about by a process of inductive reasoning, which still characterizes modern research (p.2). Briefly, this logical process appears to involve an examination of what had been previously discussed or written about the issue, an exploration of general consensus on the subject and finally the carrying out of a systematic study on all components of the area involved.

As portrayed by Markie (2013), during the post-Renaissance period, epistemology was dominated by the two main positions of empiricism and rationalism. In his article, empiricism is described as encompassing the school of thought that portrays knowledge as being solely produced by sensory perception. This is actualised by observation of the external world as perceived by the senses. Markie (2013) summarised this view as: “We have no source of knowledge in S or for the concepts we use in S other than sense experience” (sec.1).

As a result, a cognitive mapping process occurs within the being, where connections are made and new information is born. Incidentally, this is often described by the *tabula rasa* metaphor – commonly used to depict the void state of the human mind at birth – likened to a blank document, which is gradually scribbled upon by the experiences of life that the being is subjected to (Locke, 1960/1999, p.35). Central to

empiricism, lies the assertion that knowledge can only be attained after a relevant sensory experience and interaction with reality — this is referred to as *a posteriori knowledge*.

This view is contradicted by the rationalistic approach where followers argue that it is possible for the apprehension of truth without relying on the senses and to have knowledge before undergoing a real experience of the phenomena being explored. This stance depicts a picture of *a priori* knowledge. It is a position that implies that sometimes, knowledge and truth can be explored through reason and logical thinking. To this effect, Markie (2013) asserted that “Some propositions in a particular subject area, S, are knowable by us by intuition alone. We have knowledge of some truths in a particular subject area, S, as part of our rational nature” (sec.1.1).

Nelson (2005) elaborated on how rationalism embraces the principles of Mathematics as a convincing evidential source of rationalism, and it is not by mere chance that most of the rationalist philosophers were mathematicians by background (p.XV). Indeed a simple argument would revolve on how by using logic, it can be stated that in all cases, even those that have not been examined,  $2+2 = 4$ . This is what constitutes the rules of pure metaphysics, where it is postulated that objects, people, relationships and causality of phenomena can be explored through non-empirical philosophical discourse. A colourful history of the philosophy of knowledge, as painted by Bennett (2001), portrays an eighteenth century picture of scholars being strictly divided into two opposing camps: *the Rationalists* (Leibniz, Descartes and Spinoza) and the followers of *Empiricism*, namely, Locke, Berkeley and Hume. Furthermore, empiricism and rationalism were both notorious as being exclusive, in the sense that both branches strongly contended that knowledge acquisition could only be described by either of the two theories, with no possibility of a third option.

Towards the end of the eighteenth century, Immanuel Kant’s work hypothesized a synthesis of the two opposing traditions. Amongst his speculations, Kant (1781/2010) argued that sensory experiences (*empiricism*) do not provide valuable knowledge if they are not processed by logical reasoning (*rationalism*).

Concurrently, logical reason only serves as a theoretical possibility unless it is merged with and applied to actual sensory experience. In the *Critique of Pure Reason*, Kant (1781/2010) described how:

Sciences, if they can be termed rational at all, must contain elements of a priori cognition, and this cognition may stand in a twofold relation to its object. Either it may have to determine the conception of the object—which must be supplied extraneously, or it may have to establish its reality. The former is theoretical, the latter practical, rational cognition. In both, the pure or a priori element must be treated first, and must be carefully distinguished from that which is supplied from other sources. Any other method can only lead to irremediable confusion (p.11).

The connection between sensory experiences and reasoning was followed up by the theories of constructivism. A psychological perspective that is also felt to have philosophical implications shows Piaget and Inhelder (1969/2005) as notable contributors within this field by articulating how during infancy, human beings internalize knowledge by linking experiences and reflexes (p.9). Thus, at this early phase of life, the young being develops schemata which store information related to every experience that the person is subjected to. The theorists further outlined how this stored information is then used every time that the person undergoes another experience whereby, through a process of assimilation or accommodation, a schema adapts to incorporate new knowledge. When a human being *assimilates*, the new data is simply fitted into an existing framework with no major changes. However, when an experience is completely new and cannot be incorporated within an existing schema, one has to reframe the mental framework in order to fit the new experience taking place in the outside world. The later process is referred to as *accommodation*. Ackermann (2001) provided a vivid description of that which he referred to as Piaget's child, featuring as:

A young Robinson Crusoe in the conquest of an unpopulated yet naturally rich island. Robinson's conquest is solitary yet extremely exciting since the explorer himself is an inner-driven, very curious, and independent character. The ultimate goal of his adventure is not the exploration as such, but the joy of stepping back and being able to build maps and other useful tools in order to better master and control the territory under exploration (p.438).



In this section of the review, the journey of knowledge has been traced from the Platonic hypothesis about an immutable source of knowledge to modern ideas which address knowledge in a less absolute manner and allow for flexibility and diverging definitions. It can be noted that knowledge has constantly been under examination and a myriad of speculations arising from various disciplines and school of thoughts shroud this concept. It would be bold to state that this historical review and exploration of the definition and nature of knowledge is comprehensive and has given answers. Conversely, it has prompted even more questions and has instilled a greater sense of caution in attempting to address a concept that clearly has as many angles as it has different applications.

It is clear that there has been a radical shift from theories that strongly advocate a single-sided flat approach to understanding knowledge, to ones that encourage the merging of ideas and factors in a three dimensional manner. Maybe at this stage, the danger faced by epistemology would be that of losing grasp of the concept and becoming entangled within the seemingly endless quest of the exploration of the different aspects of knowledge. The risk of entering into an anarchical state where any definition is accepted without any clear defining criteria, may also hinder the progression of our understanding. Despite the varying postulations about knowledge, it is central that not every piece of information, event or statement can be classified as being knowledge and thus I believe that inclusion and exclusion criteria hold importance, despite being difficult to establish.

### **2.2.3 Relativism, realism and critical realism – an ontological perspective**

The epistemological journey that has been undertaken in the first part of the review has provided a glimpse of some of the constituents of knowledge in relation to different understandings across disciplines and historical periods. As I reflect upon the various viewpoints discussed, I can note that knowledge seems to be strongly intertwined and based upon the concept of reality. Consequently, I ask: *What is reality?* To myself, the concept of knowledge based on reality is as unsettling as it is intriguing on the realisation that a degree of what we think we know may actually be

relative to the meaning of our existence and to our subjective interpretation of reality. On side-stepping into existentialism, I sympathise with Merali's concern as she questioned reality by reporting that "as fanciful as it sounds, some philosophers have long argued that we're actually more likely to be artificial intelligences trapped in a fake universe than we are organic minds in the 'real' one" (Merali, 2013, para.3).

At this point, it may also be worthwhile to consider the experiences of Victor of Aveyron, as well as Amala and Kamala. These were feral children who serve as living examples of how the perception of reality and knowledge can be altered dramatically, simply by twisting the variables that characterize the typical childhood of an individual. In an intriguing narrative, Newton (2004) described how these children, who were raised by wild animals instead of by their blood parents, perceptualised a reality of their own, which shaped their behaviour, expectations and way of life (p.16). Like other similar cases in Newton's book, their reality was so utterly convincing that when they were taken back to the civilized world, they could not cope and longed to return to the familiarity of their known reality in the wild. Their knowledge in relation to their reality was too different. Thus, it is no wonder that reality and the knowledge attributed to it are guarded fervently, to the extent that diverging perceptions and behaviour can be frowned upon, as they can shatter an otherwise clear and logical picture of our world and existence. My reflections on the validity of knowledge in relation to reality forms the basis of the *realism* and *relativism* debate that has troubled philosophers from the Platonian period and persisted through the years by prevailing across various disciplines such as philosophy and psychology. Derksen (2010) described the realistic (pertaining to the field of realism) approach as an indulgence in experimentation in order to prove or disprove facts and then form a body of truth which shapes reality. This places emphasis on the authentic reality of the world and its use in experiments that endeavour to discover and establish facts (p.469). According to Derksen (2010), "the realist is willing to concede that some things may be socially constructed, culturally specific, subjective, or otherwise relative, but, surely, there is a bottom line, a foundation of objective reality, that cannot be relativised" (p.469).

The discourse of advocates for realism, such as Haig (2005), tends to centre on the notion of proof as a criterion for the acceptance of reality. In contrast, relativists tend to resist the perceived importance of hard proof and facts and instead adopt a preference for discussing relativity to context (Bilgrami, 2002). Hyman (2005) defined relativism as “the simplest alternative to the monistic idea that there is a single model of truth and perfection” (p.50). Davidson (1973) elaborated further by contending that beliefs or propositions are relative to conceptual schemes pertaining to different points of view (p.11).

In his regard for realism, Putnam addressed the question of whether or not the surrounding physical environment exists in an objective manner which is independent of the human mind. In his famous *Twin-Earth experiment* that featured in a paper termed *Meaning and Reference*, Putnam (1973) asked the reader to think about a scenario where a traveller lands on a planet that looks like Earth and encounters a liquid that looks like water. Putnam contended that the traveller would be right in assuming that the substance is indeed water if its molecular constitution is H<sub>2</sub>O but would be wrong if not. According to the philosopher, this is evidence that an object is real if it adheres to a set of criteria that are discovered through empirical investigation. This implies that irrelevant of the subjective opinion on the perception of an object, it is rendered real by the knowledge that it is the same *sort of stuff* and characterised by the same properties and atomic construction (p.699). Over the years, Putnam’s outlook has shifted away from a strong realist stance to an *internal realist* position. The latter view suggests that although truth and reality exist, they do so in relation to other concepts and not as standalone entities - this is thoroughly discussed in the book *Realism With a Human Face* (Putnam, 1990).

A clear argument in favour of realism and which shares the foundations of Putnam’s beliefs was presented by Sankey as articulated through his discussion of the physical world. Sankey (2008) expressed surprise and exasperation at the relativistic approach that doubts the existence of that which we touch and interact with on a daily basis. He explained how it is unadvisable to doubt the very existence of the physical environment that we live in and that any philosophy that encourages this practice is committing an anthropocentric error (p.23). The author did not deny the phenomena

of mental representations but reduced their role to a small part in the objective reality of the world surrounding us. He appealed to the plea of common sense which indicates that reality is usually as robust as it seems and this sustains a practical and shared way of experiencing life in this world. For the realist, material objects that characterise our environment are not subject to arguments entailing their reality because it is taken for granted through common sense that they are part of reality. Subsequently, Sankey (2008) asserted that:

The scientific realist who takes common sense as a starting-point is thereby justified in assuming that there is an ordinary, everyday world of material objects, with which we interact causally and to which we have epistemic access by means of our senses (p.24).

On this contention, the scientific realist is then allowed to construct theories based on this level of accepted reality. For instance, science has shown that the Earth is spherical and this knowledge has now made its entry into common sense. Thus, according to Sankey, the scientist does not have to question this fact but may regard it as definite knowledge. In his terms, “there is no need for the scientific realist to argue for the reality of ordinary, everyday material objects, since commitment to such entities has already been established at the level of common sense” (Sankey, 2008, p.24). It is interesting to note that Sankey himself mentioned the concept of anthropocentrism and perhaps this is one of the points that may counter argue his contentions about realism - Sankey’s view indicates his common sense acceptance that that which is seen is that which constitutes reality. In this contention, Sankey seemed to be assuming that humans are the ones who see and who therefore shape reality according to how they see it. In my opinion, the primary problem with this notion is that although humans seem to share a common view of certain aspects of reality, they tend to differ diversely on other issues. The very existence of these opposing viewpoints is based on the main fact that different groups of citizens in society may, at times, be experiencing a reality which is different than that of others who live in the same environment as they do. *Death and Furniture* is one of the papers that has been commonly cited during debates related to realism and relativism. The article by Edwards, Ashmore and Potter (1995) conveyed a skilful portrait of the arguments that attempt to undermine relativism. This was done by

using the two emblems: *death* and *furniture*. In a witty summary of the main arguments that characterise this field, the authors described how opponents to relativism often try to emphasise their argument by hitting a table or other furniture so as to point out the reality of that object.

However, the authors suggested that what this action simply implies is that whilst the table does have physical properties, it is still socially constructed and experienced as real only by the person who is hitting it. Furthermore, this does not provide evidence that can be applied to confirming the existence of other objects in the world. Death is the other example which realists tend to use in emphasising the real existence of this phenomenon. Yet again, Edwards et al. (1995) introduced an interesting tangent by elaborating on the various controversies surrounding the issue of death, particularly, speculations regarding the belief in an afterlife or reincarnation. As a conclusion, the authors concurred in the realisation that hitting tables and alleging that death is a confirmation of realism, is shorthand, rhetoric and ignorant. This is due to the fact that the way that these arguments are deployed is simply based on the same relative base that it attempts to disproof. On a final reflection on realism, the authors concluded that:

In its tropes of Death and Furniture we see a rhetoric that refuses to acknowledge its own existence; a politics that can claim a critical-radical credibility only by the selective use of its opponents' analytic tools; and a theology which is deeply conservative and seeks nothing less than the death of disruptive, disturbing inquiry (Edwards et al., 1995, p.42).

At this point, I would like to make a number of observations, not as a way of concluding the debate but as an attempt to make more sense of the literature. In fact, my first observation is that the various perceptions that have shaped these fierce debates do not seem to be subsiding or arriving at a mediation point. However, as illustrated by Cacioppo, Semin and Bertson (2004), it is becoming progressively clearer that sharp distinctions between the preference for realism or relativism are becoming blurred. Reference to works by key figures in this area has shown how realism and relativism tend to be complementary rather than opposing schools of thought. It may also be noted that perhaps it is the ultimate objective of both approaches that needs to be reviewed and altered. It seems as if the main energy and

effort behind both approaches is either to describe an ultimate truth or else to view the world as being socially constructed. Perhaps this same positive energy can be more effectively devoted to an integrated approach that respects diverse approaches and aims at predicting consequences. It may also be more fruitful to acknowledge that whilst reality may seem very real, there is the possibility that during some instances, this reality is not shared by all and this may not necessarily be a negative realisation.

Perhaps an answer to this debate may be found in the post-positivist philosophical field of critical realism. A distinctive belief of this form of realism holds that as individuals, we cannot have a complete lack of objectivity or knowledge about the world that is certain and unarguable. This means that in addition to our perception about any phenomenon, we need to accept the fact that there may be others which are equally valid. Consequently, Maxwell (2012) asserted that “all theories of the world are seen as grounded in a particular perspective and worldview, and all knowledge is partial, incomplete and fallible” (p.5). In this manner, critical realism is often viewed as bridging the gap between realism and relativism:

Critical realists thus retain an ontological realism (there is a real world that exists independently of our perceptions, theories and constructions) while accepting a form of epistemological constructivism and relativism (our understanding of this world is inevitably a construction from our own perspectives and standpoint)...there is no possibility of attaining a single, “correct” understanding of the world, what Putnam (1999) describes as a “God’s eye view” that is independent of any particular viewpoint (Maxwell, 2012, p.5).

Since its conception, critical realism has passed through different phases which can be traced in Roy Bhaskar’s book series on the subject. In his introductory book: *A Realist Theory of Science*, Bhaskar (1975/2008a) viewed reality as being stratified by consisting of three layers, these being “the real, the actual and the empirical” (p.2). The *real* consists of those mechanisms, events or experiences that give rise to phenomena that can be observed. However the *real* cannot be observed or directly sensed in any way. An example would be the concept of gravity which cannot be sensed but which has effects that can be tested and observed (Foster, 2013). This view is synonymous to positivism and naïve realism (as opposed to critical realism)

where the main contention holds that there is a basic reality which is mostly independent of subjectivity and relativity. The next stratum in reality is the *actual* which refers to the observable events that are caused by the *real*. Using gravity as an example of the *real*, in this case, the *actual* would be objects in a vacuum which have an increase in free fall velocity of 9.81 metres per second every second (Foster, 2013). This effect is constant and predictable and has been attributed to the concept of gravity. The final layer, which is the *empirical*, refers to the experience of the individual who is observing the *actual* and making speculations about the *real*. The critical realistic approach goes further by adding that whilst the many different views of reality do not prove that there are multiple realities, they serve to highlight the inherent human limitation in the inability to understand what is real. In view of this stratification of reality, Bhaskar (1975/2008a) concluded that in our quest to explore knowledge and reality, we may be making an *epistemic fallacy*, which is:

the view that statements about being can be reduced to or analysed in terms of statements about knowledge; i.e. that ontological questions can always be transposed into epistemological terms. The idea that being can always be analysed in terms of our knowledge of being (p.26).

As alluded to earlier, the main tenet held by the critical realist is the fact that observations may not always be clear or definite but are subject to error and so can be revised. In this view, the role of science is not to uncover the truth but to engage in an ongoing attempt to explore the various perspectives related to reality. This involves the use of triangulation by including different measures and sources each of which may be characterised by different limitations (Trochim, 2006, para.6). The critical realist claims that by addressing these multiple sources and their inherent biases, there is a better chance of understanding what is happening in reality since no single individual or school of thought can solely see reality as it really is. However the fact that different experiences, cultures and personalities may give rise to numerous perspectives is in fact a powerful tool as it prompts the critique of work carried out by others. This may enhance objectivity and may be a process that brings one closer to understand reality.

Bhaskar's earlier writings have been described as being exemplary in rigour and coherence. Indeed, I feel that his description of reality and the role of science is stark clear and particularly intriguing:

The world consists of mechanisms not events. Such mechanisms combine to generate the flux of phenomena that constitute the actual states and happenings of the world. They may be said to be real, though it is rarely that they are actually manifest and rarer still that they are empirically identified by men. They are not unknowable, although knowledge of them depends upon a rare blending of intellectual, practice-technical and perceptual skills. Thus we are not imprisoned in caves, either of our own or of nature's making. We are not doomed to ignorance. But neither are we spontaneously free. This is the arduous task of science: the production of the knowledge of those enduring and continually active mechanisms of nature that produce the phenomena of our world (Bhaskar 1975/2008a, p.37).

Further to his views on the role of science, Bhaskar (1975/2008a) differentiated between the *intransitive* and *transitive* dimensions where the former refers to the object of scientific enquiry whereas the latter consists of our conceptions of that object (p.48). In *The Possibility of Naturalism*, Bhaskar (1979/1998) attempted to address that which he regards as "the primal problem of the philosophy of social sciences" (p.1). This refers to the extent to which society can be explored and studied in the same way as nature. In his quest, Bhaskar engaged the reader in a discussion of three existing models of the connection between the individual and society. The first model which features the main contentions of Durkheim's work, views social objects as having a separate existence that is external to the individual (Bhaskar, 1979/1998, p.31). In the second model, which is represented by Weber, social objects are seen as being dependant on and the result of human behaviour (Bhaskar, 1979/1998, p.33). In the third model, which is stereotyped by Berger, Luckmann and Gidens, society and the individual are seen as being interlinked by being both the product and the cause of each other through a continuous dialect (Bhaskar, 1979/1998, p.35). In contrast to all three approaches, critical realism puts forward a Transformational Model of Social Activity (Bhaskar, 1979/1998, p.37). Whilst acknowledging the mutual relationship between the individual and society, Bhaskar (1979/1998) identified an "ontological hiatus" between society and the individual (p.40). This is brought about by the realisation that since individuals are



born in a pre-existing social context, then it cannot be said that s/he can create society but that s/he can transform it:

People do not create society. For it always pre-exists them and is a necessary condition for their activity. Rather, society must be regarded as an ensemble of structures, practices and conventions which individuals reproduce or transform, but which would not exist unless they did so. Society does not exist independently of human activity (the error of reification). But it is not the product of it (the error of voluntarism) (Bhaskar, 1979/1998, p.39).

The conclusion that emerged was that the proper way to study social structures is to focus on the various relationships that are present between societal positions and practices (Danermark, Ekstrom, Jakobsen & Karlsson, 2005, p.16). In other words, social structures cannot be studied as a standalone entity but in their natural context where they are enmeshed with different processes and situations which may be producing that very object:

Thus, whereas, in general, in the natural world the objects of knowledge exist and act independently of the process of the production of the knowledge of which they are the objects, in the social arena this is not so. For the process of knowledge-production may be causally, and internally, related to the process of the production of the objects concerned (Bhaskar, 1979/1998, p.51).

Bhaskar described his view on the relationship between social sciences and natural sciences as being a *critical naturalistic* one; being *critical* by virtue of rejecting the reduction of the social to the natural and being *naturalistic* by not accepting that there is a sharp division between the two (Gorski, 2013, p.665). In *Dialectic: The Pulse of Freedom* and *Plato Etcetera*, Bhaskar (2008b) proceeded into the second phase of critical realism, that which has been termed *Dialectical Critical Realism* (International Centre for Critical Realism, n.d.). Bhaskar's dialectic concerns the ontology of change by analysing the world in terms of discrete structures and their interaction with each other and with our thoughts and actions. This process involves four domains, these being: non-identity, negativity, totality and praxis. Gorski (2013) described the process of Bhaskar's dialect by using an atomic particle as an example (p.668). Starting from the domain of "non-identity", an attempt to study this particle may initially be characterised by the intransitive/transitive distinction and by the awareness of the real, actual and empirical layers of reality that have been described

earlier. Subsequently, we may consider how an atomic particle may be changed. It can be noted that this change may be brought about in three ways, these being: *a change in its properties* (such as a change in motion), *dissolution of the structure* or the *production of a new structure* (such as in a chemical reaction). Knowledge about these three types of changes may be applied to both the social and the natural world and constitute the Bhaskarian “negativity” domain. On further reflection, it can be noted that the *production of new structures* highlights the fact that “structures exist in systems” and the *dissolution of the old structures* shows that “structures are themselves systems” (Gorski, 2013, p.668). Bhaskar termed this ontological stage as the moment of “totality” which is then followed by “praxis” (or “transformative agency”) (Bhaskar, 2008b, p. xii). The latter refers to reflection on the knowledge obtained and planning on the best way of action.

In 2000, Bhaskar took a spiritual turn which resulted in the third phase of Critical Realism and the Philosophy of Meta-Reality (Bhaskar, 2002). In an attempt to study reality on a deeper level, Bhaskar postulated that reality has at least two layers; these being the Cosmic Envelope (Co-presence) and a lower level of Demi-Reality. Co-presence refers to the layer of reality where the human being is aware that s/he is present with other people whereas Demi-reality is characterised by alienation and social disorganisation. In this third phase of Critical Realism, Co-presence is viewed as the ultimate goal of emancipation by recognition of our unity (Bhaskar, 2002, p.91). Whilst the core messages in Bhaskar’s later writings are powerful, I feel that at times, they are hampered by obfuscation to an extent that it may be quite tedious to access the meaning. This, as well as the spiritual focus with a lack of philosophical backbone, constituted the main criticism of this most recent phase of Critical Realism especially by some adherents of this movement (Creaven, 2010).

On concluding, it is hoped that by acting as an apprentice and raising these questions about the nature of knowledge, a learning process can be followed on the acceptance that no one single view or theory can effectively explain such a complex concept as knowledge. Perhaps Critical Realism may serve as a valuable guide or source in a deeper ontological understanding of knowledge and reality and so it may be useful to further explore the application of the tenets of this movement. In respect to the area

of interest in this study, I believe that absolute realism or relativism may be dangerous in mental health and psychiatry. This is because absolute realism may be too rigid and may result in shunning alternative experiences, perceptions and ideas due to the adherence to one solid truth and reality. Contrastingly, absolute relativism may lead to a state where the main aim is to “place objectivity in parenthesis; all views, all verses in the multiverse are equally valid” (Maturana, 1985, para.1). This may be detrimental since it seems to refer to a complete endorsement of any worldview. Since I am not willing to accept certain perspectives such as coercive psychiatric practices, I would be reluctant to abide for an absolute relativistic position. This is the rationale behind my belief that Critical Realism may offer important contributions to mental health and psychiatry especially in view of the fact that so many different perspectives on this field have prevailed since its conception. In my description of Critical Realism, I have discussed the idea of a stratified reality, the relationship between natural and social sciences, the use of triangulation in exploring reality and the use of Dialectical Critical Realism. I believe that these main concepts may act as the main guides in mental health care as well as in research on this area. Some work has already been carried out in this regard. For instance, Sims-Schouten, Riley and Willig (2007) presented an example of how critical realism can be used in discourse analysis by following a systematic method which addresses the dilemma of how “to distinguish between the real and the constructed” (p.118). The result of this endeavour was termed by the authors as “a systematic empirical critical realist discourse analysis” and the method proposed may hold promise to application to other fields (Sims-Schouten et al., 2007, p.119).

#### **2.2.4 The link between knowledge, power and truth: a Foucauldian view**

The concluding section of this part of the review further explores the relationship between knowledge and truth but here in relation to power.

That knowledge is a source of power is not a novel discovery but one that has characterised social arrangement. Knowledge has tended to belong to the elite few and has been furiously guarded by this class (Rothkopf, 2008, p.xx). Knowledge has

been managed as part of the structure of power and commonly linked to a central source, such as a religious or political leader. A glance at state politics may be influential in acknowledging that in a perhaps subtler tone, this observation may ring true for the contemporary world, sometimes successfully concealed under the image of democracy. Let us, however, examine the knowledge - power link by looking at a religious scenario as exemplified by 2 giants: Islam and Christianity. In Islam, it is strongly believed that:

The very first man received revealed knowledge from Allah Himself, and was told the correct way to live. This code of life was Islam, the attitude of complete submission to Allah, the Creator of man and the whole universe (Maududi, Mawdudi, Muran & Ahmad, 1986, 1.1.3).

Notably, merging Islamic religion with the law formed the main components of the regulatory body of Sharia which governs states from their very micro level. It is therefore evident that the initial knowledge handed to man by the mystical Allah figure is the rule; that which justifies and enforces power based on this transferred knowledge. In the same tone, in Christianity, one of the crucial events portrayed in the Bible is the inscription of the ten commandments – carried out by God and conveyed through Moses (Bible Study Tools, 2014, 9:10). These inscriptions constitute the basic rules of life and sharply delineate that which is considered to be morally undesirable behaviour. Barclay (2001) discussed how unlike Sharia-Islam, these biblical laws do not specify that punishment has to be used in the event of violation (para.4). However, the Roman Catholic Church and The Eastern Orthodox Church employ the practice of confession which entails a process of penitence related to breaking one of these commandments (Hanna, 1911, para.1). Although this practice does not usually involve any physical hardship, it does point towards the instilment of moral guilt – a practice which has been perceived by intellectuals such as Foucault as a subtle act of a ruling force who is attempting to enforce control (Foucault, 1979/ 1995, p.246). This notion is discussed in detail by Cervellati and Vanin (2013) who postulated that:

A peculiar feature of moral sanctions is that they are not (or not only) inflicted by external parties but are associated to negative (self-regulative) emotions like guilt. The experience of morally induced emotions is generally the result of extensive periods of moral education during young ages and

tends to be persistent in time, thereby influencing individual behaviour and attitudes later on in life (p.15).

The extent of this control is felt to be amplified since in certain countries such as Malta, religion, tradition and constitutional law are thoroughly enmeshed. For many Maltese people, the very act of being born may subject the individual to Roman Catholic values. Notably, up to the age of 16 (minimum legal age for compulsory education), Roman Catholic studies form part of the non-optional academic subjects unless the child's parents do not adhere to this faith (Government of Malta, 1964, p.7). Interestingly, this core academic subject is referred to as *Religious Studies* - which may be understood as referring to a subject that addresses different religions and their respective dogmata with a dash of ethics and spirituality. Here is where one would realise that s/he is wrong because in reality, evidence has shown that other religions are not promoted in this subject (Vallejo & Dooly, 2008, p.5). Instead, 10-year old students engage in biblical research and learn about events described in this same book (Calleja, 2012, para.3). Moreover, it is the Roman Catholic church that governs the content of religion lessons in schools (Debono, 2013, para.21). A wedge in this argument may revolve around the young adult's ultimate freedom to make religious choices. Still, it has to be pointed out that by this lifestage, the individual would have already been exposed to a minimum of 16 years of the same doctrine, with deeply ingrained fears of hell – the ultimate outcome for those who fail to follow the moral codes of this religion.

At this point, a simple yet pertinent line of questioning would centre on the actual degree of our proclaimed freedom in society - a complex area to elaborate on, especially, in the realisation that freedom has to be accompanied by a degree of responsibility. To this extent, Foucault and Gordon (1980) contended that:

The individual is not a pre-given entity which is seized on by the exercise of power. The individual, with his identity and characteristics, is the product of a relation of power exercised over bodies, multiplicities, movements, desires, forces (p.74).

Reflections on the knowledge-power link have been articulated extensively by Foucault. In a similar way to Nietzsche, Foucault took a position where the role of

historiography is afforded less importance as a means of illuminating the origin and meaning of truth. Rather than exploring the origin of truth, Foucault instead preferred to study the link between knowledge and power. Fendler (2010) distinguished between genealogy and archaeology - processes which structure Foucault's exploration of most of the concepts in his books. She stated that "while archaeology works to understand how artefacts fit together in a historical moment, genealogy works to figure out what kind of people would fit into that set of artefacts" (Fendler, 2010, p.39). This implies an investigation of the forces which shape our current existence. Foucault's focus was not on a traditional historical narrative of events but on the concept of discourse. This entails a scrutiny of historical periods based on the theory that discourse and its associated perceived truth were modified in accordance to each period's *episteme* (the accepted manner of obtaining and arranging knowledge in a given era.) In *The Order of Things*, Foucault (1966/ 1973) described how: "In any given culture and at any given moment, there is always only one 'episteme' that defines the conditions of possibility of all knowledge, whether expressed in theory or silently invested in a practice" (p.168).

A similar pattern of investigation characterises Foucault's doctoral thesis which was eventually published under the title of *Madness and Civilisation*. Contrary to common beliefs such as those expressed by the liberal and Marxist positions, Foucault refused to perceive power as a system of oppression or as simply being overtly exercised by sovereigns. Instead, the philosopher attested that power is a network or a matrix - it "comes from everywhere" (Foucault, 1978/1990, p.93).

In his works, Foucault contended that accepted knowledge and scientific evidence are the influential factors that form an absolute truth and this is what in turn leads to the subtle exertion of power in everyday life (Foucault 1978/1990, p.93). Here, the philosopher pointed out that truth however, is not a source that has to be discovered. Rather, it is produced by a particular society's acceptance of a certain type of discourse and its usage to sanction information and declare it as true or false (Rabinow, 1991, p.7). This type of power fascinated Foucault and on further elaboration, in the book *Discipline and Punish*, he introduced the concept of surveillance through the powerful example of the architectural Panopticon model (Foucault, 1979/1995, p.204). This features an institutional design which allows a

watchman to observe the inmates without them knowing if or when they are being watched or not. Due to their lack of knowledge, inmates must constantly act as if they are being watched and this results in effective control of their behaviour. Foucault (1979/1995) regarded this structure as “a privileged place for experiments on men and for analysing with complete certainty the transformations that may be obtained from them” (p.204).

In a similar way that this mid-19th century structure allowed constant observation of segregated individuals in a prison, factory or a psychiatric asylum, Foucault theorised that observation, as an action, functions as the weaving tool of knowledge, power and truth. This system does not necessitate overtly violent coercive means of controlling behaviour in society. Instead, the direct feedback and knowledge from the observation process feeds power to the observer. Foucault (1979/1995) contended that the simultaneous application of knowledge and power in the world, has the ability to turn that knowledge into truth – hence converting it into reality and a means of disciplining and shaping the conduct and behaviour of other beings. This refers to a circular dynamic process whereas power, knowledge and truth are entwined and reinforced (p.195). The philosopher added that in addition to the type of power which is actualised by the act of observation, another form of control is in play. This refers to *self-regulation* – a continuous internal control process within individuals who can never be entirely sure if they are actually being watched or not. It may result in the self-monitoring of behaviour so that it is concordant with the expectations of society. In *The History of Sexuality*, Foucault (1984/1992) described this as the concept of *techniques of the self*, which involves:

Those reflective and voluntary practices by which men not only set themselves rules of conduct, but seek to transform themselves, to change themselves in their singular being, and to make of their life into an ‘oeuvre’ that carries certain aesthetic values and meets certain stylistic criteria (p.10).

In *Discipline and Punish*, Foucault (1979/ 1995, p.170) predicated the presence of three leading tenets in the exertion of power, these being:

- Hierarchical Observation
- Normalization and Judgment
- Examination

The philosopher noted that power and the three tenets outlined above are inherent in mechanisms of surveillance in prison, law, education and psychiatry as well as in promoting societal norms.

A Foucauldian perspective would suggest that every individual is under constant observation, wilfully and sometimes not so, and that according to the Panopticon principle, individuals are constantly being checked upon and are always subjected to the possibility of being exposed, should one's conduct be determined as unacceptable and deviant. The open architectural structure of buildings, surveillance cameras, mobile phones, journalists, blogs and social networking portals are examples of the ways in which we are scrutinised. Whilst this points towards a somewhat paranoid and claustrophobic view of the world that we are living in, realistically, we are often accustomed to these concealed forms of control and accept them as part of life and a means of ensuring our safety by enhancing the chance that dangerous activity is detected and subsequently addressed by the observers. Thus the impact of the system is not uni-directional or necessarily oppressive.

Foucault (1979/1995) recognised that whilst such societal views may seem hazardous, power is not necessarily exclusive, coercive or repressive:

We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained from him belong to this production (p.194).

Later he also claimed that "power traverses and produces things; it induces pleasure, forms knowledge, and produces discourse" (Foucault, 1980, p.119).

Whilst concurring with Foucault's view, I add that the potential danger in the application of this concept is if there is withholding of knowledge by the elite few.



Visibly, the 21st century individual is becoming aware of the latent power of knowledge and the possibility of knowledge being rendered accessible to all. This is a vital step in empowering individuals to take actions towards liberation from subjugation and oppression. One of the forces behind this change is the revolution of electronic communication which has brought the monopolization of information to a striking halt. The political writer El-Shinqiti (2010) suggested that humanity has now progressed to the next historic era – that of the sharing of information, where a single motivated individual can share information and perceptions to millions of people in a matter of minutes.

### **Criticism**

Amongst the main criticisms of Foucault's views lies that of his rejection of liberal philosophy whilst simultaneously basing the contentions of his arguments on the same values. It can be noted that critics may be right in stating that Foucault's questioning of tradition and faith echoes liberal views. However, there are definite divergences. For instance, the *Age of Enlightenment*, which saw the origins of the liberal movement, promoted science and its dominance. It is clear that Foucault is not very sympathetic to this era as he contended that values imposed by science may not necessarily be ideal (Kumar, 2007, p.11). Another point of criticism has been Foucault's inaccuracy of recounted historical events. For example, historians asserted that the Great Confinement described by Foucault in *Madness and Civilization* occurred in the nineteenth century rather than in the seventeenth century, as indicated in the book. Although this may be considered as sheer carelessness on Foucault's part, it has alternatively been regarded as arrogant disregard for meticulous work carried out by historians (Scull, 1990, p.57). Finally, it was Foucault himself who engaged in self-criticism by noting, for example, that although he had initially believed that most of his work consisted of an exploration of power, it was in fact an analysis of experience (Lemke, 2011, p.26).

In this review and study, Foucault's arguments in relation to the knowledge-power link, especially his direct adaptation of this concept to psychiatry are considered as the guiding fundamental theoretical principles.

### **2.2.5 Conclusion**

The act of exploring the general concept of knowledge was intended to allow the embarkation onto this study from a broad stance. Additionally, this part of the review acted as a catalyst for reflection upon existential issues as well as other concepts that have eventually been shaped as being facts and constituting the truth. Having now examined the platform upon which the other structures lie, the subsequent step affords a more focussed lens on the mental health field and the specific knowledge that has been attributed to it through the evolution of the mankind.

## 2.3 Mental health and psychiatric control

### 2.3.1 Introduction

*He ran amok in the cobbled street, dirty and naked. There was no stopping him...his imaginary foes were so close, too close. He had to keep running to get away. His eyes were glazed with fear and his screams were heart wrenching. They laughed at him – women on their way to the bakery stopped and whispered to each other; schoolchildren threw chunks of dirt at him and the men laughed heartily as they enjoyed what, in their eyes, was nothing more than a live circus act. Two sturdy policemen ran after him, blowing their whistles and shouting orders. He stumbled and fell as one of the men pounced on him and held him tight. The screaming became louder as he was dragged away to the confines of the dark room in the asylum. There he stayed, for the rest of his life – a mad life haunted by imaginary demons.*

Author's own

This part of the review has been divided into three sections. The first section reviews parts of the history of psychiatry and diagnosis. Originating from the Greek language: *psych* = soul and *iatory* = medical treatment (Athanasiadis, 1997, p.781). Thus, psychiatry refers to *medical treatment of the soul* – a statement that has given rise to various debates and contrasting views as shall be explored in this section of the review. The second section has been dedicated to psychiatric treatment. This involves a critical review of treatment modalities that have been used in psychiatry, in particular the asylum system, psychiatric drugs and contemporary alternative approaches. The section concludes with an exploration of evidence and the determination of its constituents. The final section in this part of the review addresses societal control and third party interests in the psychiatric discipline. This discussion is based on the works of key figures such as Szasz, Laing, Basaglia and Foucault.

### **2.3.2 What is mental illness? Opposing views and diagnostic ambiguity**

This section is intended to trace the origins of mental illness and psychiatry with a focus on the concept of psychiatric diagnosis. It has been divided into two parts – the first part (i) is dedicated to a historical review of psychiatric diagnosis with particular emphasis on kraepelinian dichotomy and the neo-kraepelinians. The second part (ii) is constituted by a critical discussion of opposing views in relation to the validity and benefit of a psychiatric diagnostic system – here reference is made to various movements such as anti-psychiatry and critical psychiatry as well as the User Movement.

#### **i). A brief history of psychiatric diagnosis**

##### **Psychoanalysis, psychodynamics and Kraepelinian dichotomy**

The status of mental illness during the Middle Ages and prior to the 18th century is one that triggered many questions and contemporary debates. Psychiatry has attempted to provide various explanations to that which had been perceived as mystical and bizarre. Finally, it has resulted in the structuring of clinical categories and management pathways that dictate treatment and care. Today's psychiatry may resemble a phoenix rising from the ashes – a novice creature that has the wisdom of its predecessors yet the knowledge and the aptitude that may promise better outcomes. It cannot be negated though that one resemblance between the new bird and the old one is the rulemaking characteristic – the privilege attributed to psychiatry to distinguish the normal and acceptable from that which is regarded as abnormal and treatable.

The fundamental debate and the foundations of the psychiatric discipline are rooted in the quest to define and conceptualise mental illness in an attempt to erect clear boundaries between normality and madness (Unger, 2013). In his comprehensive work about the history of psychiatry, Shorter (1997) recounted how psychoanalytic and psychotherapeutic theories dominated the post-asylum era and the biological approaches that featured in the 19th century. For more than half a century, Freud's

ideas, in particular, were at the forefront of explanations that tended to focus on social and non-biological explanations of symptoms related to mental illness. This approach centred around the contention that actions and thoughts are often controlled by forces that can only be explored through a process of psychoanalysis. Although the profound effect of Freud has seeped into today's psychiatry, the major critique surrounding this school of thought is that Freud's theories were simply his, because they could not be studied empirically and so lack scientific validity (Brace, 2006).

Kraepelin, a German psychiatrist, was one of the critics who shunned Freud's psychoanalytic postulations, in favour of biological and pathological understandings of mental illnesses (Kraepelin & Diefendorf, 1902). In this way, he opted to consider mental illness as a state of predisposition to stressful events in life. This led him to contend that "so-called psychic causes – unhappy love, failure in business, overwork – are the product rather than the cause of the disease, that they are but the outward manifestation of a pre-existing condition" (Kraepelin, 1962, p.132). In addition to his studies about the use of psychiatric drugs for treatment of disorders related to the nervous system (pharmacopsychology), Kraepelin's pioneer work lies in his classification of mental illness. The first form of a classification and diagnostic system - which ultimately led to the American Psychiatric Association (APA)'s *Diagnostic and Statistical Manual (DSM)* is still widely in use today (Hacking, 2013). This was fuelled by Kraepelin's interest in using empirical methods in the exploration and description of mental disorders. Following years of observing patients and recording symptoms related to mental illness, Kraepelin introduced the innovative Kraepelinian dichotomy which initially constituted two main divisions: *manic-depressive psychosis* (nowadays termed bipolar disorder) and *dementia praecox* (later renamed as schizophrenia) (Kraepelin, 1962, p.131).

In a critical appraisal of the history of psychiatry, Decker (2007) highlighted the events that took place during the 1880s and 1890s, when Kraepelin slowly grouped symptoms and categorised them for publication in *Compendium der Psychiatrie* (Kraepelin, 1883). One of Kraepelin's main strengths was his prowess as a descriptive author, as seen by the colourful manner by which he described the symptoms.

Although one of the main criticisms of Kraepelin's work centres around observer bias and the validity of preconceived notions, one must note that Kraepelin was aware of the importance of experimental psychiatry and he had designed his own methods of testing mental reactions to various substances and external factors, as guided by Wundt (Ebert & Bar, 2010, p.191).

Notably, Kraepelin advised that psychiatrists should refrain from focusing on the origins of illness and from postulating a diagnosis but should instead focus on the observation of the symptoms and description of the manifestations (Decker, 2007, p.340). To me, this bears resemblance to one of the pillars of contemporary psychiatry - the *Recovery Movement* - which affords more consideration to addressing and describing symptoms rather than placing diagnosis at the hub of care (Roberts, 2011).

Decker commented that Kraepelin's view point seemed to change over time since in the fifth edition of his book *Psychiatrie*, he indulged in the aetiology of dementia praecox. A notable aspect about Kraepelin is that throughout the course of his life, he often reflected upon his work and even admitted that his proposed nosology was not definite and subject to scrutiny. In response to critique by Meyer, Kraepelin acknowledged a further shortcoming in that he did not review existing literature in order to substantiate his work (Hippius, Peters & Ploog, 1987, p.159). Following the second world war, Kraepelin's approach waned in popularity in favour of environmental and psychological movements. In particular, psychologists were required in the treatment of shell shock especially in view of the fact that psychiatrists were short in supply (Reisman, 1991, pp.100-102) and soon after, psychotherapy was added to the discipline (Routh, 2000, p.236).

### **The Neo-Kraepelinians**

The psychoanalytic and psychodynamic thinking that dominated the scene in the 1940s was characterised by a negative perception of psychiatric diagnosis in that it could be harmful to patients (Kendler, Munoz & Murphy, 2009, p.134). For instance,

Beck, Ward, Mendelson, Mock and Erbaugh (1962) reviewed systematic studies of the reliability of psychiatric diagnosis and reported an agreement of only 54 percent for specific diagnoses (p.351). Similarly, studies by Sandifer, Pettus & Quade (1964, p.355) and Schmidt & Fonda (1956, p.266) revealed agreement in just half of the cases between two independent opinions on diagnosis of a group of patients. Kendel et al. (2009) narrated how during the same period, a group of psychiatrists at Washington University were preoccupied with the fact that the psychological approach that had gained popularity lacked a scientific base (p.135). In the 1960s and early 1970s, these psychiatrists, who became known as the *neo-kraepelins* expressed their dissatisfaction with a discipline that seemed to be unstructured, non-medical and non-scientific. Their preoccupation with these flaws led to an echo of Kraepelin's fundamental belief that only an empirical, biologically-based evidence base can improve the outcomes for those who exhibited symptoms related to mental illness (Decker, 2007, p.348). Once again, a cautionary note against over-emphasis on aetiology was made due to the lack of knowledge about the origin and causation of most psychiatric disorders.

The culmination of these hypotheses and assumptions led to a paper published in the *Archives of General Psychiatry* (Feighner, Robins, Guze, Woodruff, Winokur & Munoz, 1972). The paper outlined a review of 1000 articles which formed the background of a proposal for new criteria for psychiatric disorders. The objective of such an extensive review was to present a diagnostic system that was based on evidence as opposed to "opinion or tradition" and described by the authors of the paper as "the most efficient currently available" (Feighner et al., 1972, p.62). In agreement, Macalpine and Hunter (1974) stated that:

The lesson of the history of psychiatry is that progress is inevitable and irrevocable from psychology to neurology, from mind to brain, never the other way round. Every medical advance adds to the list of diseases which may cause mental derangement. The abnormal mental state is not the disease, nor its essence or determinant but an epiphenomenon. This is why psychological theories and therapies, which held out such promise at the turn of the century when so much less was known of localisation of function in the brain, have added so little to the treatment understanding of mental illness despite all the effort devoted to them (p. 256).

Furthermore, the new categorisation was fuelled by the follow up of case studies and rigorous observation of the course of psychiatric illness. This was a sharp contrast to the *DSM-II* which centred around psychoanalysis as well as a committee's judgement and experience (Spitzer & Fleiss, 1974).

Klerman (1978, pp.104-105) suggested nine tenets as the basis of the neo-Kraepelinian movement:

- Psychiatry is a branch of medicine.
- Psychiatry should utilize modern scientific methodologies and base its practice on scientific knowledge.
- Psychiatry treats people who are sick and who require treatment.
- There is a boundary between the normal and the sick.
- There are discrete mental illnesses. They are not myths, and there are many of them.
- The focus of psychiatric physicians should be on the biological aspects of illness.
- There should be an explicit and intentional concern with diagnosis and classification.
- Diagnostic criteria should be codified, and a legitimate and valued area of research should be to validate them.
- Statistical techniques should be used to improve reliability and validity.

As a result of this movement, the *DSM-II* was revised and its revolutionary sequel was produced as directed by the influential psychiatrist Robert Spitzer (Decker, 2007, p.351). The *DSM* system has paved the way for a modern diagnostic system and its use has spread widely in the field of psychiatry. However, subsequent publications were characterised by opposing views that challenge validity and reliability, especially in the recent launch of the *DSM V*. In Kendler et al.'s words: "There is, we suggest, a healthy dialectical tension between nomothetic (law-based) and ideographic (individual case) approaches to psychiatry and between scientific explanation and psychological understanding" (Kendler et al., 2009, p.141).



This tension shall be explored in the next section as part of the critique of the concept of a psychiatric diagnostic system and its implications.

## **ii). Diagnostic criticism: a matter of pseudo-science?**

Diagnostic criteria have indeed been the subject of controversy (Summerfield, 2008). Diverse perceptions have ranged from an exclusively clinical psychiatric model of diagnosis to theorists who posited that psychiatry and its alleged ability to diagnose disorders is simply a fabrication or a myth.

The psychiatric model proposed by Spitzer and colleagues that has been described in the previous section has found some acceptance and the *DSM* series has now reached its fifth publication (APA, 2013). Similarly, the psychiatric diagnostic system proposed by the World Health Organisation (WHO) as seen in the *International Classification of Diseases (ICD)* manual, is undergoing its 11th revision and expected to be published in 2017 (WHO, 2014).

The psychiatric model that features in the *DSM 5* and the *ICD 10* continues to have both critics and advocates. One of the critics - Summerfield (2008) - discussed the significance of culture – a case in point being the South African ailment of *thinking too much* which has similar symptoms to depressive disorder but a different meaning in this particular culture. This led Summerfield (2008) to state that “Western psychological discourse is setting out to instruct, regulate, and modernise, presenting as definitive the contemporary Western way of being a person. It is unclear why this should be good for mental health in Africa or Asia” (p.993).

In an exploration of some of the debates surrounding the medical model, Szasz (2010) described how diagnostic subjectivity, the boundaries of normality, coercion, conceptual disputes about the mind and brain, freedom and other human rights have generated the anti-psychiatry movement that saw its rise in the 1960 s. In their review of critical psychiatry, Bracken and Thomas (2004) explored how the contradictions and disagreements in psychiatry which gave rise to the anti-psychiatry movement during the 1960s and 1970s, still feature in the contemporary mental

health field, having now progressed to a critical psychiatry perspective and most recently a postpsychiatry viewpoint. In a parallel fashion to this movement, groups of ex-patients have expressed their dissatisfaction with mainstream medicine by forming *survivor groups*. These are often characterised by a quasi-militant approach to the psychiatric discipline by a group of individuals who consider themselves as survivors of traumatic and oppressive medical practice (Wallcraft & Bryant, 2003). These movements and groups, as well as other prominent ones, shall be explored in further detail in this section.

The aim of this section of the review is not that of indulging in a crusade against conventional psychiatry or else as a historical journey. Instead, some of the main debates and movements that characterise the mental health field shall be discussed and critiqued since I believe that these play a major part in shaping discourse on mental health and the therapeutic alliance. At this point, I wish to disclose the knowledge that despite my effort to avoid complete bias in my writing, I do not adhere to a modernist view that may advocate the possibility of complete objectivity and non-bias. Rather than hiding beneath an objective veil, I am attempting to view a controlled degree of bias as fruitful since it was this very bias that initially fuelled my interest to undertake this research study. My position in this argument is not one in favour of the medical model and yet I do not profess to be on the antipsychiatry pole. On reflection, I conclude that the postpsychiatry approach is the one that tends to attract my sympathy.

### **The antipsychiatry movement**

Desai (2005) noted that despite the emphasis on regarding psychiatry as a branch of medicine, it is characterised by striking differences from the other areas found within medical practice (p.185). As a case in point, the idea of anti-cardiology, for instance, is not plausible, whereas the area of anti-psychiatry is a well-defined movement that has a definite place in society. One may relate this to the historical Cinderella status of psychiatry. However, on further thought, such open hostility towards psychiatry, such as that expressed by Thomas Szasz, may well be led by the lack of tacit evidence regarding the practices of this discipline:

This view rests on a serious, albeit simple, error: it rests on mistaking or confusing what is real with what is imitation; literal meaning with metaphorical meaning; medicine with morals. In other words, I maintain that mental illness is a metaphorical disease (Szasz, 2007, p.6).

The works by Szasz and other prominent figures in the anti-psychiatry movement, such as R.D. Laing and David Cooper, shall be explored in further detail in a later part in this section of the review.

In a series of papers dedicated to the evidence-base of psychiatry, critical psychiatrists Bracken and Thomas (1999a) scrutinised the medical model that has been prominent in unearthing the aetiology of a number of psychological disturbances. The authors postulated that an error may have been made when the medical model was extensively applied to all forms of psychological disturbances in a quest to prove that these symptoms were part of a specific mental illness that had a physical basis and could be treated likewise. In their publications, Bracken and Thomas mentioned schizophrenia as a typical example and labelled it as the *raison d'être* of psychiatry – a disorder that has been researched and stripped of human experience in order to form a biomedical picture. They also reasoned that although neuroscientific advances may fill the evidence gap, accurate and practical diagnostic tests are still fantasies that have yet to be actualised. Hence diagnosis is still mainly reliant on professional observation making it susceptible to subjective bias and political influence. Bracken and Thomas (1999a) identified the power imbalance that the medical model creates within the therapeutic alliance and stated that there is a need for “a fundamental shift in the power relationship between doctor and patient. Psychiatry has to hand over responsibility for psychosis to those who experience psychosis. Those who experience psychosis must be prepared to accept that responsibility” (para. 4).

In one of his works about learning difficulties and society, Goodley (2001) expressed similar misgivings about the notion of power that characterises the Social Model of Disability and Impairment. He contended that “society creates disablement and is the arbiter of disciplinary powers that (re)produce pathological understandings of different bodies and minds” (p.210). In the same paper, Goodley (2001)

elaborated on support interventions found within a continuum of deficit at one end and capacity at the other end. This views individuals with learning difficulties in terms of levels of competence/ incompetence and of a model based on pathology, problems and incapability.

The anti-psychiatry movement, which began to form in the 1960s, mirrored this observation and raised several questions pertaining to the perceived robustness of the newly constructed psychiatric discipline (Desai, 2005). Prior to delving deeper into the diagnostic challenge, the history of the anti-psychiatry movement is going to be explored with focus on the main phases and viewpoints that characterise this movement.

Desai (2005) described how the first of the major steps in the anti-psychiatry direction was taken by a science fiction writer, L. Ron Hubbard, who, in 1950, founded the Church of Scientology (p.185). In 1969, the Citizens Commission of Human Rights (CCHR) was founded by scientology in an attempt to unveil the perceived evils practiced by psychiatry: “to expose and eradicate the brutalization of patients in the name of ‘mental health’. Over the years, the Citizens Commission has investigated and exposed thousands upon thousands of cases of psychiatric negligence, abuse and brutality” (Scientology.org, 2014, para.5).

Hubbard’s preoccupation with what he clearly perceived as being barbaric practice was communicated through a number of his publications. He believed that psychiatry is a worldwide conspiracy run by the Union of Soviet Socialist Republic (USSR) (Hubbard, 1967). A critical point regarding these assumptions follows the power issues that seem to lie behind such claims. It is felt that while Hubbard’s attack on psychiatry’s lack of consideration for the spiritual aspect may be well placed, whether scientological practices have a positive outcome on the course of mental illnesses has yet to be proven. Cases such as the notorious one of Lisa McPherson who was brought dead to hospital following introspection rundown – a scientological spiritual technique that attempts to treat florid psychosis, fuels doubt in this regard (Murphy, 2012).

The second wave of the antipsychiatry movement saw the involvement of professionals such as psychiatrists and sociologists who questioned the basis of psychiatric diagnosis and treatment as well as the coercive authority linked to it (Desai, 2005). Adolf Meyer had been one of the earliest 20th century leading figures who opposed the use of diagnostic criteria as a primary and sole means of diagnosing mental illness. Contrasting with similar movements that challenged conventional psychiatry, Meyer did not distinguish between mental disturbances that should be dealt with by the medical profession and those that should be treated as social problems (Meyer, 1952). Echoing the views of other radicalists such as Szasz (1974a), Meyer (1952) endeavoured to explain schizophrenia in terms of maladaptation to life experiences and an unhealthy lifestyle: “living in ways which put their mind and the entire organism and its activity in jeopardy” (p.4).

One of Meyer’s concerns was that psychiatric practice lacked scientific evidence (Meyer, 1951). In order to partially address this issue, he postulated reaction-type systems that served the purpose of a structured analysis of abnormal responses and remarked that psychiatry should be more organised and disciplined. He proposed a classification system that was “a wide range of facts usually left to untrained common-sense, but now available as a more and more organised body of facts, methods of study and methods of therapeutic procedure” (Meyer, 1951, III, 44). Meyer’s scepticism regarding any diagnostic system as complete or as a steadfast rule featured in his works - he even described his own system as not being “sufficiently settled for practical purposes” (vol. II, p.136).

The base of Meyer’s contention, which is one of today’s debates in psychiatry, holds that the medical model focuses too much on bodily parts, namely the brain, and is generally reluctant to seek connections to the lived experience of the individual. Meyer (1952) shunned the over-inflated importance of statistical research techniques and emphasised that a higher level of insight can be obtained through person research (IV, 6-7). An interesting point that was specifically argued by Meyer (1951) was that the primary aim of the psychiatrist needs to be that of collecting the facts and not to produce a diagnosis: “If the facts do not constitute a diagnosis we must nevertheless act on the facts” (II, 146). He cautioned against the obsession with

making a diagnosis that is often aimed to satisfy the psychiatrist's craving for tying up the symptoms in a neatly organised parcel that is linked to a ready-made treatment package (Meyer, 1951, II, 136). On reflecting upon Meyer's main arguments, I believe that it is necessary to really question the significance of a biological diagnosis, what it says about a person's life and what it adds to it.

In view of approaches such as that articulated by Meyer, the act of diagnosing may be understood in terms of the application of a label, leading to an erosion of an individual's identity and medicalisation of symptoms which may be caused by non-pathological factors. Yet this voice has been subjected to counterarguments by a number of service users who, through the adoption of a biological model, have found great relief in being offered a medical reason (a diagnosis) for their symptoms (Huibers & Wessely, 2006, p.895). Despite the stigma and sick role attributed to such diagnoses, the act of having an explanation and a validation of symptoms is akin to other medical disorders and in itself, this has been a source of comfort for these individuals (Fulford, Broome, Stanghellini & Thornton, 2005, p.83). For instance, in an article about the consequences of diagnosis, Heitler (2012), who is a clinical psychologist, described how one of her patients who used to be irritated by her feelings of anxiety gained more control over these symptoms by becoming aware of the clinical label of the state of anxiety: "By clinically labelling her feeling anxiety, she was able to use her new knowledge of what to do in the face of specific emotions" (para.20).

This argument is also exemplified by the book *An Unquiet Mind* - a compelling memoir by Kay Jamison (1995) who described her life as characterised by bipolar disorder. Jamison clearly portrayed her acceptance of her symptoms as situated in understandings pertaining to genetics, pathology and medical imaging results. For her, the origins are solid, organic and based on scientific evidence. This has allowed her to seek the necessary treatment and progress with her life – a successful life characterised by multiple research endeavours and a professor post at Johns Hopkins School of Medicine (Jamison, 1995).

Although criticisms of the theory and practice of psychiatry such as those expressed by Meyer have been evident throughout the nineteenth and twentieth century, it was

the South African psychoanalyst David Cooper who introduced the term anti-psychiatry. He stated how “a more profound questioning has led some of us to propose conceptions and procedures that seem quite antithetic to the conventional ones – in fact what may be regarded as a germinal anti-psychiatry” (Cooper, 1967, p.ix).

In a similar manner to Meyer, Cooper favoured a psychosocial approach to the origin of mental illness and attributed disorders to a dysfunctional family system. He argued that in the family, permissible behaviour is regulated through complex double-binds – this is a type of political control of the members. An interesting tangent raised by Cooper involves his view that madness is in fact a process of restructuring. He argued that if this process is not interfered with, the person can emerge from the experience with gains above his pre-morbid level of functioning: “Madness is a permanent revolution in the life of a person...a deconstitution of oneself with the implicit promise of return to a more fully realized world” (Cooper, 1980, pp.37,51).

Cooper’s views seemed to echo in two simultaneous attacks on conventional psychiatry, as presented by psychoanalyst R.D. Laing and psychiatrist Thomas Szasz. Huddleston (2006) described how Laing’s work featured in 1960 when following his medical training with the army, he began to doubt the use of placing psychiatric patients in deep insulin comas as well as the use of electroconvulsive therapy. It was instantly clear that his position was that of viewing mental illnesses as a normal reaction by sensitive individuals to a mad world:

If the human race survives, future men will, I suspect, look back on our enlightened epoch as a veritable age of Darkness. They will presumably be able to savor the irony of the situation with more amusement than we can extract from it. They will laugh on us. They will see that what we call 'schizophrenia' was one of the forms in which, often through quite ordinary people, the light began to break through the cracks in our all-too-closed minds (Laing, 1967, p.107).

He also ventured into comparing determinism to the more beneficial approaches of subjectivity and freedom and emphasised that cure can only happen when the

individual is left free to choose. Laing's first book, namely: *The Divided Self* involved case studies that were used to challenge the notion of schizophrenia. In doing so, Laing (1960) revolutionised the way that mental illness is perceived and interpreted, particularly by arguing that psychosis is not a biological ailment but a normal reaction in the face of ontological insecurity. The latter term refers to insecurities related to one's existence and to an individual who is not able to "take the realness, aliveness, autonomy and identity of himself and others for granted" and who then embarks on a mission to avoid "losing his self" (Laing, 1960, pp.41-3). Laing structured this contention on the theory that our existence in the world is defined by mental models carried by ourselves about those around us. He theorised that psychosis arises when there is tension between our private inward persona and the model that we present to the world, which leads to a division of the self, as a defence mechanism. This split is characterised by the classical symptoms of schizophrenia. Using his case studies and sociograms as evidence, Laing discovered that the bizarre and inexplicable symptoms exhibited by patients often make sense when they are viewed against the backdrop from which they emerge.

Applying the concept of *The Double Bind Theory* by Bateson, Jackson, Haley and Weakland (1956), Laing (1960) elaborated on the fact that in malfunctioning family systems, a child can find himself/herself in a situation where, in order to enjoy parental affection and approval, s/he has to comply to a self-identity that has been constructed by his/her parents (p.191). This is usually different from how the child internally experiences himself/herself to be, which results in a dilemma and a potential psychotic response.

In his later work *Sanity, Madness and the Family*, Laing and Esterson (1964) explored how individuals interact and how this may relate to schizophrenia. Essentially, this described the notion of schizophrenogenic families and included sharp criticism on the way in which institutions such as schools oppress individuals by attempting to mould their thoughts and feelings in a way that is dictated and accepted by society. In *Self and Others*, Laing (1961) discussed the terms "phantasy" and "unconscious experience" which refer to the latent, internal authentic lived



experience which cannot be observed by others but can only be inferred through discussion:

I think of me being inside my body and at the same time the inside of my body being somehow 'inside' my private space. If someone comes into my room unasked he does not intrude upon me to the same extent as if he were to enter my body without permission. However since I am inside my body, my body is also outside me in some peculiar sense (p.18).

The determination to challenge the validity and reliability of psychiatry was shared by psychologist and lawyer D.L. Rosenhan, whose 1973 sensational article, published in the prestigious journal *Science* was cited and quoted in debates that followed. This article - *On Being Sane in Insane Places* - was intended to indicate that American psychiatrists did not have scientific diagnostic standards and that an individual's stay in a psychiatric hospital was an irrational experience. These views had been tested by a fascinating observational study carried out by the researcher in order to demonstrate that false diagnosis is a very real possibility in psychiatric settings.

The study featured Rosenhan and seven other 'normal' people who went to different psychiatric hospitals on an individual basis in order to attempt to be admitted. The reason that they gave for their admission request was that they were hearing voices that said "empty", "hollow", and "thud" (Rosenhan, 1973, p.382). These invented symptoms were ones that had never featured in psychiatric diagnosis, yet, in each case, the "pseudopatients" were falsely diagnosed as suffering from a psychiatric disorder which merited admission (Rosenhan, 1973, p.383). As soon as the pseudopatients were admitted, they started to behave 'normally' and did not report any further symptoms. The task that each individual had was to try to convince the staff that s/he had recovered and so could be discharged. The striking results showed that even though the pseudopatients had been admitted on a voluntary basis and were behaving in a perfectly normal manner, Rosenhan and his collaborators were admitted for an average of 19 days (Rosenhan, 1973, p.384). In one case, the admission period was nearly two months. Furthermore, upon discharge, the 12 individuals were labelled as "schizophrenia in remission" and this was entered into their permanent medical record. Thus, they were never certified as having truly

regained their sanity (Rosenhan, 1973, p.384). Interestingly, Rosenhan asked the study participants to take field notes about their interactions with staff members and it was instantly noted that the professionals attempted to “depersonalize” patients and avoid significant interactions with them. For instance, the pseudopatients kept a count of the responses that they were given when they approached staff members to ask questions. It could be noted that an alarmingly high number of professionals refused to make eye contact when approached or spoken to (Rosenhan, 1973, p.388). Rosenhan’s critics outlined various limitations related to the ethical and methodological rigour in the study such as, for instance, Rosenhan’s possible inclination to inflate the negative aspects of the participants’ experiences inside the psychiatric hospital. Still, I feel that his study is imperative in magnifying one recurrent crucial question: How accurate, valid and reliable is a psychiatric diagnostic system?

Simultaneously, Szasz started to harshly question the existence of mental illness in relation to its comparison to medical disorders. Szasz (2007) argued that the main difference between medicine and psychiatry can be explained by the fact that in generic medicine, disorders were discovered whereas it seemed that in psychiatry, they were simply invented (p.xv). This made them “counterfeit diseases” and “non-diseases”: “If you talk to God, you are praying; If God talks to you, you have schizophrenia” (Szasz, 1973, p.101). He hypothesised that these myths were perpetuated by the state and by psychiatrists’ wish to safeguard their profession and preserve their power and control: “the state is primarily an apparatus of coercion with a monopoly of the legitimate use of violence” (Szasz, 2007, p.151).

Szasz’s example can be taken to a further level by noting that one of the concepts in psychiatry is that of insight - this refers to a person’s ability, or lack of, to recognise that s/he is suffering from a mental illness (Markova & Berrios, 1992, p.850). It may not be inaccurate to note that this does point towards a situation where a person’s failure to comply with mainstream psychiatric ideas may be at risk of simply being written off as lack of insight. On exploring the concept of insight in relation to recovery, Timimi (2011) noted that “paradoxically, it has been found that the presence of this type of “insight” (meaning accepting you are mentally ill and need

medical treatment) is negatively correlated with emotional well-being, economic satisfaction and vocational status” (sec. *Prognosis*).

Szasz’s description of the notion that modern psychiatric experts invent diseases does not seem too far-fetched in view of the ever-expanding, seamless boundaries of the current systems of classification. This argument was one of many that were introduced by Frances (2009) in his criticism of the recently published *DSM 5* – this shall be explored in more detail in a later section in this review. In what has been widely considered as one of the best arguments against conventional psychiatric practice, Szasz’s book: *The Myth of Mental Illness* shunned the generally accepted view that mental illness is like any other bodily illness and medical speciality (Szasz, 1974a). The author’s critique revolved around the fact that symptoms attributed to mental illness are simply imitations due to the fact that if an ailment has to be classified as a true disease, then it has to be considered with and compared to the rest of medical practice (Szasz, 1974a, p.47). This refers to measurement and testing in a scientific fashion as well as pathological demonstration at the cellular or molecular level. This is a vivid contrast to how mental illnesses had been historically voted into existence by agreement amongst members of the APA – and the subsequent shaping of diagnostic labelling:

Every science consists of classification, control, and prediction; hence to prove psychiatry is a science, the psychiatrist classifies, controls, predicts. The result is that he classifies people as mad; that he confines them as dangerous (to themselves or others); and that he predicts people's behaviour, robbing them of their free will and hence of their very humanity (Szasz, 1973, p. 115).

Szasz (1960) contended that although the manifestation of mental disturbances may resemble pathological diseases, they are simply but wholly, problems in living and in morality: “Our adversaries are not demons, witches, fate, or mental illness. We have no enemy whom we can fight, exorcise, or dispel by ‘cure’. What we do have are problems in living — whether these be biologic, economic, political, or sociopsychological” (p.115). Another area that held the focus of Szasz’s criticism was involuntary mental hospitalisation. In a 2006 documentary film called *Psychiatry: An Industry of Death*, Szasz emphasised that involuntary mental

hospitalization is a crime against humanity which can easily result in “pharmacocratic” dictatorship (Citizens Commission for Human Rights, 2006). This view shares a number of similarities to Foucault’s critique of the penalty system and the self-regulation process induced by constant supervision. Foucault’s works shall be explored in further detail later in this section but as a final note, it has to be added that Szasz’s views also resemble Foucault’s in the sociological origin of mental illness. For instance, Szasz (1970) discussed how “in the past, men created witches: now they create mental patients” (p.xxiv). Similarly, in *Madness and Civilisation*, Foucault (1961/2001) noted that:

Leprosy disappeared, the leper vanished, or almost, from memory; these structures remained. Often, in these same places, the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals, and "deranged minds" would take the part played by the leper (p.5).

It has to be noted that, as described in an article by Buchanan-Parker and Barker (2009), Szasz has often been misinterpreted (p.89). In fact, he has been frequently wrongly associated with the anti-psychiatry movement of the 1960s and 1970s. Szasz (2009) himself pointed out that he is only opposed to the practice of coercive psychiatry – on the other hand, he is in favour of a contractual psychiatric service between consenting adults with no involvement of the state (p.ix). Moreover, in his book *Antipsychiatry: Quackery Squared*, he criticised the anti-psychiatry movement and regarded it as an imitation of psychiatry:

Antipsychiatrists imitated psychiatrists by means of a childish negativism: they constructed antitheories of schizophrenia, which they called ‘existential-phenomenological accounts of madness’, established anti-hospitals, which they called ‘households’ and defined as ‘ideal psychiatric communities’ and provided psychiatric treatment which they called ‘trips’, that often entailed the use of mind-altering (psychotropic) drugs (Szasz, 2009, p.4).

As discussed by Bracken and Thomas (2010), one of the outstanding characteristics of Szasz’s writing is its clarity - this serves to add coherence and consistency to his analysis and his attempt to demystify psychiatric diagnostic labelling (p.220). On the other hand, his form of thinking has been criticised as being too rigid and that it may have been misinterpreted as being an attack on the concept of mental illness (Double

2010, p.5). Furthermore, Double (2010) contended that one should be careful when making such harsh statements against psychiatry because mental health services are still needed and specific diagnoses may help to address and alleviate one's suffering through giving meaning to a group of symptoms (p.5). He added that the problem arises when diagnostic categories are simply regarded as biomedical concepts that omit the psychological and social aspects during assessment and care planning.

Echoing Szasz's critics, it has to be noted that whereas some of the earlier *DSM* versions simply involved a committee's consensus on voting psychiatric disorders into existence, the APA (2013) described how nowadays such illnesses are tested in a scientific manner that is supposedly more rigorous (para. 5). Still, it seems as if this scientific method itself may not be appropriate, as articulated in the response given by the Society for Humanistic Psychology to the publication of the *DSM 5*. The society's view is that the proposed diagnostic criterion is largely based on social norms and on subjective judgments:

The putative diagnoses presented in *DSM-V* are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgments, with little confirmatory physical 'signs' or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations (Society for Humanistic Psychology, 2012, Divison 32, sec.9).

This enhances the risk of medicalising responses that are based on normal variations rather than pathology – these responses may require help but not necessarily psychiatric help:

Clients and the general public are negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation (Society for Humanistic Psychology, 2012, Divison 32, sec.9).

The constitution of evidence that serves as the base of psychiatric knowledge shall be explored in further detail in a later part of this section.

In a counterargument that advocates the medical model, it has to be noted that the history of generic illnesses resembles that of mental illnesses due to the fact that before aetiology and treatment were understood, management was generally ineffective (See Loudon, 2002). This implies that psychiatric disorders are part of a field that is still evolving and so it may be more accurate to consider them as misunderstood rather than as non-existent. However opposing arguments hold that the problem is much more serious and related to deep cracks in the facade of modern psychiatry (Angell, 2011).

Desai (2005) described how the third major antipsychiatry force originated from England in the 1970s (p.186). This was led by the *Mental Patients Union* which consisted of those who called themselves survivors of psychiatry. The union was also influential within a larger movement, namely the *World Network of Users and Survivors of Psychiatry*. In a similar manner to their predecessors, activists sought to deny the existence of mental illness and the cold and clinical manner of psychiatric practice. Irwin, Mitchell, Durkin and Douieb (2011) published a rare cope of *The Fish Pamphlet* which may have been the starting point of the British Survivor Movement in 1974:

Psychiatry is one of the most subtle methods of repression in advanced capitalist society. Because of this subtlety, few recognise the dangers shrouded by the mystification of 'modern medicine'. The psychiatrist has become the High Priest of technological society, exorcising the 'devils' of social distress, by leucotomy (butchery of the brain), electric shock treatment - ECT (plugging brains into mains), and heavy use of mind-controlling drugs. The mental patient is a sacrifice we make whilst we continue to serve the Gods of the Capitalist Religion (p.23).

Noorani (2013) explained how the movement was particularly successful in improving the nature of psychiatry by bridging the gap between service providers and service users (p.54). This shall be explored in more detail in the following section.

### **The user movement**

Notably, over the past forty years, many critical service user/ survivor movement groups have emerged as a result of the antipsychiatry move (Wallcraft, Reed &

Sweeney, 2003, p.11). Examples of these groups include *Survivors Speak Out*, *Mad Pride*, *Mad Women*, *National Self Harm Network* and the *Hearing Voices Network* (Holland & Blood, 2009). The main objectives of these groups is advocacy and to provide a consultancy service to mainstream mental health services. Additionally, they favour a political stance whereas professionals in areas of health care are urged to relinquish paternalistic manners of addressing mental illness and instead focus on sharing knowledge and power with those who seek their service (Noorani, 2013, p.53). The magazine *Asylum* serves as an exhibition of works that echo the main tenets of the user movement:

A consultant once said to me that he wanted to increase my medication. I asked him to state his reasons: Was it to iron out or flatten highs and lows in my thoughts, because I could get quite manic? The doctor said that was not the case, and that was paranoia on my part. I replied that the reason I had said that was not because I knew it to be true, but that I was just speculating, to see if the doctor would agree or disagree, or offer another reason. In effect, it was playing with words or indulging in a mild form of trickery, so as to harmlessly get some information. It was interesting to see how quickly the doctor jumped to the wrong conclusion, due to the psychiatrists' mindset towards their patients. I then explained what I was doing by asking him that, and the doctor laughed, especially when I pointed out that he may be the one suffering from paranoia. Of course I was joking. How many patients are misdiagnosed and on the wrong amounts of medication because of misunderstandings between them and their doctors? Many, I would suggest. And how many are labelled paranoid when they can't express themselves as I did? Once again, many (Anonymous user in a medium-secure unit, 2011, p.9).

In 2003, a report named *On Our Own Terms* which was based on research carried out by the English service user/survivor movement was published (Wallcraft, et al., 2003). This publication consisted of a detailed survey on the consistency, operating procedures and future plans of the multiple groups within the movement. A number of findings outlined the important activities that were being undertaken by groups within the movement. For instance, education and training were popular activities within groups:

We are going to be doing some work around relapse prevention, not a term I particularly like, a piece of jargon. It's a model from the States, it's much more a social model which treats people as individuals. People have their own plan that they go through training to develop, so it's very much around self-management and taking responsibility yourself for your own signs of

distress and what you do about them. The person is at the centre of it, but it includes services as well as individual things and people's own strategies as well. They will go on to train professionals in using it so it moves up from there (Wallcraft et al., 2003, p.16).

The experience of being a member of this movement was explored by Knight and Kierans (2011) who carried out a narrative inquiry with five members of user movement groups in order to elicit the rationale and the meaning of participation. Interestingly enough, being part of a service user movement group was perceived as creating a sense of community and solidarity due to the experience of engaging with people who have had similar experiences:

And I got on there...everybody had the same feelings as me ... 'this is wrong, we've not been treated properly', and for me that was so empowering because it was like a whole online community that was together and so there was this sense of community (Knight & Kierans, 2011, slide 6).

On an individual basis, it had an additional empowering effect whereby some of the members who were interviewed reported that due to their participation, they became aware that they wanted to move out of feeling like a "user", which is connoted to disabling implications:

Do I stay 'user' or this person down here, or do I make major changes, and start looking at this process of stopping being this disabled, disabled person...and I just went for it, and became self-employed (Knight & Kierans, 2011, slide 9).

This consequently led to another beneficial outcome which was that of helping others in the same situation. Another reason was the pride experienced by being a change agent within a mental health system that was perceived as being harmful and ineffective:

It has been a vital part of my recovery and it's been a vital part of feeling something, a purpose in life, there is a purpose in my life beyond my immediate family and everything, that there's, I am actually doing something useful, that really is very, very important (Knight & Kierans, 2011, slide 14).

One criticism of survivor movement groups has been based on the observation that despite their value in giving a voice to the person who is experiencing mental difficulties, there may be a lack of representation. This is due to the fact that service



user groups seems to be mainly made up of people who have had negative experiences in relation to their mental health as well as to the services that they sought (Wallcraft et al., 2003, p.38). Anger seems to be a common catalyst within group members. Furthermore, it has to be acknowledged that other factors such as gender, age, sexuality and culture contribute directly to the experience of mental illness and these need to be adequately represented in the movement groups.

### **Critical psychiatry and post psychiatry**

Alongside the emergence of the user movement, contemporary interpretations of the experience of mental illness have carved a competing niche to the biomedical model which has held prominence for countless years. These emerging viewpoints ranged from the logical and humane to that which is somewhat bizarre and perhaps even risky. As an example, one particular explanation of mental illness by the American psychologist Louis A. Sass, may be seen as being particularly intriguing and somewhat different from the biological and sociological explanations that have been explored so far in this review. In his book *Madness and Modernism: Insanity in the Light of Modern Art, Literature, and Thought*, Sass (1992) elaborated on why schizophrenia remains a mysterious condition. Primarily, Sass (1992) argued that madness results due to “confrontation” (p.207). This confrontation entails a human’s realisation that his existence is a framework that facilitates interpretation of the world. In usual circumstances, the individual is not consciously aware of this phenomenon or of the fact that reality is constantly being constructed in a particular manner. A state of hypersensitivity and hyperalertness, often seen in a psychotic state, may be symptomatic of this “confrontation”. In this sense, it is erroneous to view “madness” as a deficit state because it is in fact a state of “hyper-realisation” (Sass 1992, p.79).

Interestingly, Sass (1992) pointed out that madness, specifically psychosis, bears a striking resemblance to art, whereas many modern artists and writers seem to be expressing very similar preoccupations as individuals who are understood as being mad (p.36). Sass progressed to list these preoccupations - these include an exploration of reality and relativism, defiance of authority, fragmentation and a total

loss of self – often exhibited in the art and literature by artists such as Franz Kafka, Paul Valery, Samuel Beckett, Alain Robbe-Grillet, Giorgio de Chirico and Salvador Dali. Through the use of a phenomenological approach to explore the cognitive similarities between illness and genius, Sass (1992) referred to the tendency of both to deconstruct reality and human experience and so in a parallel manner, both states involve being in a hyperreflexive state and a sense of alienation from the world (p.67).

In what feels like a sequel to this book, in *The Paradoxes of Delusion: Wittgenstein, Schreber, and the Schizophrenic Mind*, Sass (1994) presented an unorthodox view of the inside of the schizophrenic mind by comparing Daniel Schreber (a jurist who spent 13 years in asylums due to mental illness) and Ludwig Wittgenstein (a central philosopher in twentieth century thought). Sass (1994) contradicted the conventional view of schizophrenia as a disease and pictured it as another means of viewing reality rather than as a treatable or suppressible condition:

The standard conceptions, whether psychoanalytic or psychiatric have nearly always presupposed the Western's enduring equation of sanity with reason, insanity with passion and error – as if madness were necessarily a kind of stupidity or dementia, or in terms of Plato's famous metaphor, a case of the wild horse of instinct overwhelming the charioteer's conscious control (p.10).

Instead of interpreting the symptoms of schizophrenia through a biomedical lens, Sass (1994) opted for a philosophical approach that analyses subjective and objective realities as well as how we judge these reality types. Reflecting on Sass' work, Bracken and Thomas (1999a) asserted that this is a serious contention since in psychiatry, schizophrenia is considered a dogma and questioning its existence as an illness has the potential to shake the very foundations of this discipline (para. 2). In a typical postmodern view, these same authors pointed out that one has to be cautious when proposing the denial of the existence of psychosis or when picturing it as a wonderful experience of self-discovery. This is due to the fact that reality has shown that oftentimes, it is an extremely distressing and debilitating condition. However, medicine should refrain from promoting psychiatric understandings and medical treatment as absolute and ideal solutions since these tend to de-humanise the experience:

Unlike the antipsychiatrists, we do not deny the existence of psychosis, nor do we seek to romanticise it as a journey of self-discovery. For most people psychosis is a terrifying, perplexing experience. But the medical model has failed in its task to account for psychosis, and in doing so it has wrenched the ownership of the experience from the sufferers, denying them their own attempts to make sense out of the experience (Bracken & Thomas, 1999, para. 3).

Figures such as Patrick Bracken and Philip Thomas are the main protagonists in critical psychiatry and postpsychiatry. Other leading figures are Joanna Moncrieff, Duncan Double, Sami Timimi and Bradley Lewis (Kecmanovic, 2009).

A number of authors who are linked to the critical and post psychiatry period have been clear in their critical explanations about what constitutes the recent progress in psychiatry (Bracken & Thomas, 2001). In fact, most of this progress is mainly related to the development of new drugs, neuroscience, molecular genetics and Cognitive Behavioural Therapy (CBT). The main concern here is that the components of this progress are based on assumptions that may or may not be accurate. Whilst a number of diagnostic endeavours and treatment approaches are a direct branch of the medical model, other therapies such as CBT are still rigidly rooted in beliefs about the nature of self, the environment and the construction of reality (House & Loewenthal, 2008, p.11).

At times, it is quite clear that unlike antipsychiatry, critical and postpsychiatry are not a blatant attack on anything related to medicine and conventional psychiatry (Lewis, 2006). Alternatively, the main philosophy shifts towards respecting human autonomy and the right for choice and freedom - it is not to say that mainstream psychiatric services are not useful, desirable and effective in some cases. However, it is about the need to widen the horizon and partake a humble approach by realising that for the time being, diagnostic labelling and the explanation as well as the treatment options that it provides, are simple hypothesis and not facts; it is one way of looking at reality or rather, one way of describing reality. Thus, assuming that it is the only way or the best description of reality would be subject to error (Bracken & Thomas, 2001, p.727). Having its philosophical roots in a postmodern approach, critical and postpsychiatry encompass a more holistic way of addressing madness

and distress. The main ideas are drawn from philosophers such as Foucault, Merleau-Ponty, Wittgenstein and Heidegger.

Despite their common goal that psychiatry needs to be practiced without the underpinning foundation in terms of brain pathology, postpsychiatry and critical psychiatry differ in a number of ways. In brief, the main difference lies in that critical psychiatry is mostly concerned with the politics and ethics of psychiatry as well as encompassing a number of philosophical positions (Thomas, 2013, para.4). In contrast, in his book *Moving Beyond Prozac, DSM, and the New Psychiatry: The Birth of Postpsychiatry*, Lewis (2006) described how postpsychiatry is more focussed on postmodernism and concerned with the modernist's tendency to look for technical solutions to address life's problems. According to postpsychiatry advocates, progress can be achieved by engaging with the service users in a creative manner rather than by imposing psychiatric rules on those who we call patients: "Contemporary psychiatry tends to focus on neurochemical and genetic explanations, to place technological solutions over ethical and human considerations, and to use forced treatment methods to resolve clinical controversy. By contrast, postpsychiatry works to counter these trends" (Lewis, 2006, p.x).

Some of the advocates of critical and postpsychiatry such as Phil Thomas, Patrick Bracken, Duncan Double and Joanna Moncrieff formed critical psychiatry/psychology groups such as *The Critical Psychiatry Network (UK)*. Originating from England, this network has spread internationally and includes multiple philosophical positions which may not all be conceptually linked to postmodernism. Activists are mainly preoccupied with the political and ethical aspects of clinical psychiatric practice as well as an effort to limit the influence of the pharmaceutical industry on psychiatry and mental health care (Double, 2002, p.324). The views on the impact of the pharmacological industry shall be discussed in a later section of this review.

An article by Kecmanovic (2009), bearing the notable title of *Postpsychiatry: How to throw out the baby with the bathwater*, challenged the fundamental concepts of the postpsychiatry movement. Primarily, the author argued against the insistence of advocates of postpsychiatry in de-prioritising traditional psychiatric diagnosis as this

risks a distraction from understanding the problem in a holistic person-centred approach:

For example, frontal lobe tumor may underlie someone's low energy levels, depression, confusion, forgetfulness, lack of initiative and loss of interest in people and matters. Should psychiatrists first look for the meaning of such symptoms in the patient's social context, and thereby let his or her mental and most likely physical state as well deteriorate; or should they first rule out any possible physical-biological cause of the said symptoms? (Kecmanovich, 2009, p.278).

In the subsequent argument, the author reasoned that with the exception of involuntary treatment, the psychiatrist does not attempt to impose a diagnosis on a patient but simply provides advice to someone who has voluntarily sought the psychiatrist's opinion:

In a good number of cases patients do not have their own view of where their mental problems came from. (After all, that is why they look for professional assistance.) They can accept or reject the psychiatrist's interpretation, or might be indifferent towards it. If they accept it, and the results of the treatment turns out to be below the patients' expectations, patients are free to seek assistance from another psychiatrist who follows the principles of another psychiatric model (Kecmanovic, 2009, p.279).

Although these words ring true, it is felt that such a view may be too rosy and generalisable since advice constitutes "guidance or recommendations" (Oxford Dictionaries, 2013, p.67) and not the moulding and presentation of information as a certain and absolute fact as may happen in recorded cases of coercion (See Caplan, 2012).

In the cases of more severe conditions such as psychosis, which may lead to involuntary treatment, Kecmanovic (2009) then justified the imposition of the psychiatrist's diagnosis due to the fact that the patient's mental pathology may limit his/her ability to interpret his/her symptoms correctly. He argued in favour of this practice by describing it as being: "The same right *mutatis mutandis* a physician has to impose on a patient an explanation for his or her for example jaundice or bleeding, or impaired sighting that may conflict with the patient's reading of these troubles" (p.279). Taking on a postmodern stance, once again, I feel that this (psychiatric

symptom interpretation) may sometimes be a question of perception rather than an absolute fact. Hence in psychiatry, the value and ethical correctness of imposing an interpretation onto an individual is dubious.

Finally, Kecmanovic (2009) used Spitzer's words as the last say in this argument by sharing his view that a proposal of a joint diagnostic system between the service provider and the service user is not practical or necessary (p.279). On a critical note, it has to be said that since Spitzer was the leading figure in the production of the new *DSM* versions, it is hardly surprising that he seems to prefer a psychiatrist's diagnostic monopoly. Thus, I feel that Kecmanovic's citation of Spitzer's words may not be an adequate justification for his argument about psychiatric diagnosis. In fact his words seem to be justifying the notion of disciplinary power which featured in Foucault's ideas about psychiatric power and the state:

We can say that disciplinary power...fabricates subjected bodies; it pins the subject-function exactly to the body. It fabricates and distributes subjected bodies; it is individualising...the individual is nothing other than the subjected body. All this constitutes the disciplinary individual and finally fits somatic singularity with political power (Foucault, 1973/2008, p.55).

In the second part of his article, Kecmanovic (2009) addressed the issue of treatment and recovery (p.280). The author accurately described how generally, postpsychiatrists argue against the proven effectiveness of pharmacotherapy. He also elaborated on the postpsychiatry view that the term recovery is not synonymous to treatment and it does not imply a complete resolution of symptoms. Rather, it is applied to a state of being where the individual is enjoying a good quality of life enhanced by a sense of freedom and the ability to "speak out". It is rather disappointing that the building of these arguments led to a rather abrupt and short counter-argument by the author where he simply stated that experience has shown that psychosis triggers hostile reactions from society and so it has to be treated professionally. I view the conclusion of this article as being the most valuable section since the author refrained from taking sides and alternatively reflected on a recommendation by Jakovljevic. This refers to the suggested use of pluralist and integrated approaches as these may be the most promising contemporary concepts of psychiatric practice (Jakovljevic, 2007 as cited in Kecmanovic, 2009).

## **Multiple fronts and no man's land**

On further personal reflection, I perceive the mental health domain as a tug of war of opposing viewpoints with *illness* on one side of the spectrum, *genius* on the other, and *reactions to problems in living* featuring somewhere in between. It cannot be denied that opposing mainstream and radical views add fascinating dimensions to this area. However I feel as if excessive effort has been and perhaps is still being devoted to proving or disproving mental illnesses and their management, in other words, to being pro- or against psychiatry.

The startling realisation here is that without questioning any side's honest intentions, it may be the case that the person who is experiencing mental illness, may be losing his/her status as a keyplayer and is being overruled in a struggle for power brought about by owning a monopoly in the knowledge pertaining to this field. If this is the case, it may be that we are at risk of restricting the person to wander in no-man's land whilst each front focuses on the next plan of action to shape current knowledge and maintain power. It is felt that the important question that needs to be re-shifted into focus centers on how these debates are going to help the person who is passing through the experience of that which may be perceived as a mental illness.

My belief is that perhaps the answer may not be so dependent on whether one embraces a medical/ psychiatric view, or indeed an anti- or a critical psychiatry one, but on the ability to be receptive to different theories of knowledge and on having the practical intelligence to apply them appropriately in different circumstances. Without attempting to introduce yet another movement, these thoughts, which are similar to those expressed by Jakovljevic (2013), may serve for the future of the mental health field. Notably, Jakovljevic (2013) added that in psychiatry, there is no one unified theory and practice, but a plethora of theories and practices that range from pharmacotherapy, electrical stimulation, psychological therapies, education and life coaching:

Different schools of thought assessing mental health and mental disorders have given rise to different perspectives of psychiatry: the medical or disease perspective, and the dimensional, cognitive, behavioural, narrative, spiritual

and systems perspectives. Each of these perspectives tends to analyze, understand, define and treat mental disorders in different ways, each with their own merits, albeit without enough success (p.203).

Unfortunately, this loose assembly of approaches has been the target of criticism in relation to a lack of clear pathways (Jakovljevic, 2013, p.203). However, it may also be viewed as a strength since it provides service providers and service users with various options that can be explored and tested as a matter of personal preference and effectiveness. Only, of course, if the person is provided with different options and encouraged to utilise any resources that for him/her, may be meaningful in making sense of his/her experience.

### **2.3.3 The treatment debate**

The previous section has involved an exploration of the history of mental illness with a focus on the various understandings and debates that have characterised psychiatric diagnosis. The aim of this section is to explore some of the perceptions related to the treatment of symptoms that are supposedly caused by a mental illness. The section has been divided into three parts – the first part (i) takes the reader through a brief history of treatment-related views. The subsequent part (ii) concerns opposing views of the appropriateness and effectiveness of psychiatric treatment. The third part explores some contemporary alternative approaches in mental health as exemplified by the symptom that is medically termed as psychosis. Finally, this section of the review concludes with part (iv) that attempts to critically question and address the constitution of evidence.

#### **i). A brief history of treatment-related views**

Advances in psychopharmacology and psychological therapies have been significant in improving the quality of life of some of the individuals who were experiencing symptoms synonymous to mental illness (Psychiatry Central, 2006, para.2). A multitude of clinical trials as well as convincing patient narratives have shown that mainstream psychiatric treatment, mainly drugs such as antipsychotics, antidepressants, anxiolytics and mood stabilisers have a significant beneficial effect (See Reid, 2013; Leucht, Hierl, Kissling, Dold & Davies, 2012; Jamison, 1995).



Medical guidelines, such as those issued by the National Institute for Health and Care Excellence (NICE), recommend and guide the use of drugs and psychological therapies in most of the psychiatric conditions found in the *DSM* and *ICD*. Furthermore, there seems to be a consensus that the move in psychiatry is towards less restrictive community care with hospitalisation being left as a last resort (WHO, 2007).

Still, in a similar manner to the diagnostic debate, psychiatric treatment has been characterised by a history of opposing views, debates and a confusing and non-conclusive ocean of clinical trials. In *Madness and Civilisation*, Foucault (1961/2001) carried out a philosophical examination of psychiatric treatment. As a point of origin, he described how initially, madness had been seen as something that had to be restricted rather than treated, although later, the idea of treating mental illness gradually became accepted. Still, as Foucault pointed out, treatment was not based on medical contentions but was rooted in morality and body-soul links:

To the moral world, also, belongs the madness of just punishment, which chastises, along with the disorders of the mind, those of the heart. But it has still other powers: the punishment it inflicts multiplies by nature insofar as, by punishing itself, it unveils the truth (Foucault, 1961/2001, p.26).

In the same book, Foucault (1961/2001) differentiated between behavioural treatment techniques used in the nineteenth century which were based on morality and earlier bodily techniques such as purification, immersion and movement regulation which were still aimed at purifying the soul (p.232). The main difference here is that nineteenth century techniques did not restrain the madman, however they made him fear his carers and to dread the consequences of indulging in undesirable behaviour.

Foucault chose Philippe Pinel and Samuel Tuke in order to develop his argument about the asylum system. Foucault (1961/2001) outlined how Tuke's philosophy, as seen in the Quaker institution that he founded, was based on guiding the patients through a process of self examination and internal dialogue (p.234). This meant that the residents were not physically abused as seen in prior modes of treatment. Instead

the terror related to these physical methods was replaced by a method of repression that was focused on wakening the patient's conscience through the instillation of guilt. Here Foucault (1961/2001) placed particular emphasis on the power of observation as a form of control and restraint (p.237). This has to be seen in the view that those who were observing the patient had the power to categorise observed behaviour as being desirable or not and consequently actualise a judgement system. This is the basis of what gave power to psychiatry. Foucault's central point, and one of great interest is that although psychiatry may have moved out of the years of visible barbaric treatment, in reality, patients have been freed from physical constraint but are now restrained within the chains of their conscience as guided through the medical discipline (Foucault, 1961/2001, p.262). This may indicate a change in the method of application of power – from an overt way to a covert one.

Pinel's system was also based on conscience in a time where political criminals were starting to be distinguished from psychiatric patients. Importantly, Pinel was not in favour of religious conscience or morality – his approach to the focus on conscience was drawn from values in the outside world and their imposition onto the patient. Patients were encouraged to speak about their symptoms, with the exception of delirious discourse (Foucault, 1961/2001, p.242). Foucault (1961/2001) related this theme to the use of psychological treatment, which, in his eyes, is also based on morality rather than on science (p.264). The philosopher devoted particular detail to Sigmund Freud's psychoanalysis – in his opinion, this type of treatment does not involve judgement or punishment and this means that it can explore mental illness in a more effective way. However, Foucault doubts its effectiveness since he theorised that engagement with unreason can only be achieved successfully through art and other modes of creativity.

Another leading figure in the treatment debate was Thomas Szasz. Szasz (1974a) reasoned that in general medicine, if a person does not have symptoms of an abnormal biological condition – clear hard proof of a malfunctioning organ - then s/he is not usually considered as being ill and as being a patient (p.101). This is due to the fact that Western medicine rests on two tacit convictions: that of diagnosing and treating bodily disorders and doing this with the patient's consent. The logical

conclusion that follows is that psychiatry cannot really cure, if such a thing as mental illness does not even exist and so psychiatry is simply engaging in pseudomedical and “pharmacomythological” interventions:

The war on drugs is the current psychiatric-judicial pogrom. And so is the war on children called “hyperactive”, poisoned in schools with the illegal street drug called “speed”, which, when called “Ritalin”, is a miracle cure for them (Szasz, 2000, sec 1).

Notably, Szasz (2007) made use of a television set analogy where he insisted that the quality of a program on television cannot be improved by interfering with the set wiring (p.6). Therefore, a television engineer cannot address problems such as viewers disliking a particular program because such issues are dependent on external factors such as the acting and script. Similarly, “problems with living” cannot be addressed by interfering with physiological mechanisms and using the same logic, psychiatrists are not equipped to treat psychological problems. Szasz (2007) concluded that the act of using medical terminology to address such problems is detrimental to the individual and simply causes oppression and further chaos: “We call jokes ‘sick’, economies ‘sick’, sometimes even the whole world ‘sick’; but only when we call minds ‘sick’, we systematically mistake and strategically misinterpret metaphor for fact – and send for the doctor to ‘cure’ the ‘illness’ ” (p.6).

Here, the author outlined that he is only opposed to state psychiatric services due to their coercive nature and the tendency to limit individual freedom. His view was that an individual should seek a service on his own free will, essentially without the involvement of the state and so treatment should never be imposed:

If a person wants a book, he can go to a store and get it or get it on the internet. He ought to be able to get a drug the same way. If he doesn't know what to take, then he could go to a doctor or a pharmacist and ask them. And then he should be able to go and buy it (Szasz, 2000, sec.3).

Other radical figures, such as Laing and Cooper also shared their views in the opposition to psychiatric treatment. Cooper perceived asylums as a symbol of political repression of the working class. He attempted to explore other treatment approaches that were not based on a medical model. In 1962, he set up an

antipsychiatry unit called Villa 21. The aim of the unit, (like Kingsley Hall that followed it), was to destructure the typical psychiatric ward environment. Thus, professionals and patients did not wear a uniform and attempted to address emotional difficulties through non-responsive involvement (Cooper, 1967, pp.93-94).

Berlim, Fleck & Shorter (2003) summed up Laing's views by stating that Laing refused to acknowledge that any professional status or knowledge is required in the treatment of mental illness (p.64). According to Laing (1967), the "healer role" was one that could be taken up by any individual who was concerned and willing to help: "Psychiatrically, this would appear as ex-patients helping future patients to go mad" (p.128). For Laing, the role of the treatment setting was that of a sanctuary where individuals could be supported to go through their "process of madness":

The journey is experienced as going further 'in', as going back through one's personal life, in and back and through and beyond into the experience of all mankind, of the primal man, of Adam and perhaps even further into the being of animals, vegetables and minerals (Laing, 1967, p.126).

Furthermore, Laing asserted that psychiatrists and psychotic individuals are not all that different; any visible gap only exists because of the psychiatrist's professional training that promotes the alienation of the care receiver. Additionally, he emphasized that clinicians should attempt to debunk their assumptions about reality and madness whilst providing care (Laing, 1960, p.33). Simultaneously, professionals need to realise that the patient's perception of his/her situation is as valuable as that of the clinician's.

In a similar manner to Cooper, Laing's practical contribution to this debate came in the form of a residential treatment community centre that was opened by this psychiatrist in 1965 and lasted till 1970 (O'Hagan, 2012, para.3). Five decades later, those who experienced this setting recall a dramatic era of discovery. The core leading group consisted of Laing, Cooper, Esterson, Briskin, Redler, Berke, Schatzman and Liss. During the existence of *Kingsley Hall*, there was a rapid turnover of therapists with Laing remaining present all throughout its existence. In

total, 130 patients stayed at the place (O'Hagan, 2012, para.9). The underlying philosophy of Kingsley Hall was that of allowing and encouraging the full force of the experience of episodes related to mental illness without any suppression or structured therapy. Resembling a subculture, therapists and patients resided permanently in the house and through a destructuring of the therapeutic milieu, several patients experienced regression and rebirth. O'Hagan (2012) described how the place did not have any locked doors and no anti-psychotic drugs were used (para.4). There was a meditation room and all-night therapy with a focus on regression to childhood, role-reversal sessions and planned entertainment.

Although Laing's anti-psychiatry experiment has not been thoroughly tested for effectiveness, Harris (2012) tracked down and interviewed 13 people who resided at *Kingsley House* during the five-year period of its existence. The narratives that emerged are contradictory yet thought provoking. For instance, Francis Gillet, one of the residents, recounted how: "Ronnie [Laing] said, 'Go mad, young man', and I did. I took him at his word, and I went as mad as I possibly could, and at no time did he try and stop me" (Harris, 2012, Interview 2).

One of the most famous and successful individuals who passed through this place was Mary Barnes, who described how during her Kingsley stay, she had regressed to infancy and indulged in behaviour such as bottle feeding and crying for attention. Subsequently, she later emerged as a celebrity artist and poet (O'Hagan, 2012, para. 5). Controversially, other residents described Laing's free distribution of high-grade LSD which was supposed to release childhood traumas and inner evil spirits. Notably, one of the residents stated that Laing resembled a shaman but conflictingly he still worked as a psychoanalyst – something that in the resident's opinion, made Laing a contradictory, difficult and irresponsible being (O'Hagan, 2012, para. 47).

Berlim et al. (2003) described how in the 1960s, Laing and Szasz emerged as radical left figures but their effect on psychiatrists or on Health Department policies was not very significant. In contrast to them, Goffman presented strong arguments that in mental hospitals, psychiatrists held so much more power than the patients that the whole system was rendered anti-therapeutic. This proved to be adequate justification

for the closing down of many hospitals as guided by the conviction that this was in the patients' interest (Berlim et al., 2003, p.65). As articulated by Eisenberg (2010), the process and consequences of deinstitutionalisation have shown that psychiatric hospitals did have some scope after all (p.97). This is because when in some countries psychiatric hospitals were downsized or closed, a large number of patients were rendered homeless – crimes ensued and this situation perpetuated the stigma related to mental illness. In view of these different views and approaches to treating individuals perceived as being mentally ill, it seems to me as if the state has a clear yet very complex problem: that of managing unreason.

## **ii). The effectiveness of psychiatric drugs**

### **A crusade against drug effectiveness**

The effectiveness of psychotropic drugs has been one of the most controversial areas over the years. Figures like Moncrieff (2013a; 2013b), Healy (2009) and Breggin (2006) have presented research that contradicts the promoted and evidenced effectiveness of commonly used drug types in psychiatry. Bracken (2012) stated that over recent years, the evidence that psychiatric drugs function through a placebo effect cannot be contradicted. The author cited two meta-analyses carried out by Turner and Kirsch which have concluded that in 80% of the cases explored through individual studies, the improvement seen was very much comparable to that experienced by participants in placebo groups (p.56).

Double (2001) acknowledged that reviewing the literature about the effectiveness of psychiatric drugs is a complex task due to the vast amount of studies, different methodologies and the need to appraise the quality of studies located (p.25). Several researchers have endeavoured to undertake this process. Double (2001) described how in 1974, Morris and Beck were amongst the first to synthesise the data available by looking at trials published over a 14-year period (p.25). Their results showed that in more than half the cases, antidepressants were more effective than placebo. However, Bracken and Thomas (2004) theorised that the main mode of function of antidepressants is through the generation of hope. Since hope may be generated

through alternative, less invasive methods, the authors postulated that discourse in mental health should feature issues such as hope, meaning and values.

Thase (1999) reported that the evidence for the effectiveness of antidepressants is not robust and it has to be acknowledged that there is a significant placebo effect (p.333). Similar findings were later reported by Kirsch (2009) whose research showed that a significant difference between placebo and antidepressants is only witnessed in very severe cases of depression (p.318). In 1995, Moncrieff had also explored the effectiveness of the mood stabiliser lithium and expressed dissatisfaction due to her observation that results obtained are neither clear nor significantly demonstrated:

Differences between lithium and placebo treatment in several of the trials were probably attributable to discontinuation of lithium increasing the likelihood of manic relapse in placebo treated subjects. In the largest prospective trial, treatment conditions for the two groups were not comparable (Prien et al 1973a), and in another prospective trial only a select group of subjects were considered and results were presented in a way which impedes a proper understanding of the data (Moncrieff, 1995, p.571).

In a later trial by Bowden et al (2000), which is considered as the largest clinical trial in this area, there was no significant difference in the subjects' response rates to lithium and to a placebo (p.485). In addition to the fact that the effectiveness of drugs has been placed under scrutiny, Evans (2004) also cautioned about the inadequacy of the double-blind methodology that is used in many clinical trials (p.14). This is due to several factors. For instance, patients may note that the placebo tablets that they have been taking taste differently from the usual medication. Active medication may also be characterised by side effects which distinguishes it from placebo. Treatment that is regularly used to manage psychosis has also been under scrutiny. In 1998, Thornley and Adams explored the effectiveness of drugs used in the treatment of schizophrenia over the past 50 years. A total of 2000 trials were included in the review. The findings showed that the overall quality of the studies was poor and this may have led to inaccurate overly positive results in relation to the effectiveness of these drugs (Thornley & Adams, 1998, p.1183). Bracken and Thomas (1999b) discussed how rather than viewing drugs as the medical cure, it is

advisable to talk and describe the experience of psychosis during a dialogue with the patient:

It is often assumed that in irrational states, such as psychosis, there are constraints on a person's ability to act autonomously. This view may be used as justification by a psychiatrist to disregard the patient's treatment preferences. But situations in which a person is irrational in all aspects of thought, will and action are rare (p.328).

In 2010, Irving Kirsch compiled his research around this area in a book called *Antidepressants: The Emperor's New Drugs*. His views were similar to other leading figures and he outlined his concern that the drug industry may be a culprit in promoting the pseudo-effectiveness of psychiatric drugs:

The drug effect seemed rather small to us, considering that these medications had been heralded as a revolution in the treatment of depression – blockbuster drugs that have been prescribed to hundreds of millions of patients, with annual sales totalling billions of pounds (Kirsch, 2010, p.11).

This concern echoes the thoughts of critical psychiatrists in relation to the evidence base underlying the biomedical model. Notably, Kirsch did not shun the use of medical treatment as he realised that this may be of use in particular cases. His perception is similar to Higgins' (2008) who indicated that the place of medical treatment should be that of an “invited guest” rather than an “overarching paradigm” (p.11).

In 2013, Peter Breggin, another prominent figure in the effort to limit the abusive prescription of psychotropic drugs, presented a guided system to psychiatric drug withdrawal in his book: *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and their Families*. The aim of the book was to offer guidelines to assist the prescriber and therapist in helping patients to withdraw from psychiatric drugs. Breggin (2013) elucidated how research revealed the danger of long-term exposure to psychiatric drugs due to their relation to obesity, diabetes, heart disease, abnormal movements and a detrimental effect on the quality of life (p.3). These dangers have led Breggin to advise that the best option in modern psychiatry is to encourage withdrawal from psychiatric drugs.



## Counter arguments

Despite the convincing nature of these arguments, which are indeed supported by research, it is interesting to note that the opposing side of the argument is similarly based on a multitude of research which seemingly demonstrates the effectiveness of the commonly used drug types in psychiatry (Kohler, Gaus & Bschor, 2014; Maher et al., 2011; Vieta et al., 2010). Leading figures in this area, such as Leucht et al. (2012) have cautioned against the crusade against psychiatric drugs due to the consequence that it can have on patients: “In this context, many psychiatric drugs not only improve the acute episode but also prevent further episodes. Patients with severe, recurrent depression might have 20 episodes in their lifetime, which could be reduced by medication to 10” (p.103). They described that controversy about medication effectiveness can result in individuals who decide to discontinue their medication – this can easily be a catalyst to suicide or relapse. These researchers have devoted effort to proving the effectiveness of psychiatric drugs through various randomised controlled trials and meta-analysis. One particular study involved an overview of 94 meta-analyses in an attempt to demonstrate that the degree of effectiveness of psychiatric drugs compares well to other drugs used in general medicine (Leucht, et al., 2012). In an echo of Moncrieff and Cohen’s views (2009), it has to be said that whilst the consequence of stopping effective medication is acknowledged, however, it may be equally harmful to mislead patients into believing that psychiatric drugs are overly-effective or can provide a cure. In a chain of publications, Moncrieff distinguished between a *drug centred model* and a *disease centred model* (See Moncrieff, 2010; Moncrieff, 2009; Moncrieff 2007). She described how the drug centred model may be more empowering as it views psychiatric medication as an extrinsic substance that mainly works through producing cognitive and emotional suppression:

The disease centred model is captured by the idea that drugs act by correcting or partially correcting an underlying biological lesion, analogous to the way the action of most drugs in general medicine is understood. In contrast the drug centred model suggests that drugs work by inducing their own abnormal brain states (Moncrieff, 2007, p.296).

This suppressed state may be beneficial in certain circumstances, such as in acute psychotic states. However, in an example brought by Moncrieff and Cohen (2005), once the acute episode has been controlled, the person may then decide to stop antipsychotic drug use and instead engage in alternative forms of maintenance treatments (p.151). This is different and probably more beneficial than adherence to the disease centred model which assumes that psychiatric medication is physiologically corrective.

### **iii). Contemporary alternative approaches**

#### **The psychosis example**

Dutch psychiatrist Marius Romme has been one of the pioneers in developing alternative approaches which view symptoms characteristic of psychosis as meaningful and that have to be explored and understood rather than suppressed or disguised. He posited that accepting and coping with auditory hallucinations - a symptom that is often attributed to a state of psychosis - can enhance one's quality of life in a better way than simply ignoring the voices (Romme, 2009, p.4). Indeed, he believed that struggling against the voices only causes them to become stronger. In his publications such as *Accepting Voices* (Romme & Escher, 1993) and *Making Sense of Voices* (Romme, 2000) as well as others published in the journal *Mind*, Romme described an innovative approach involving the extraction of meaning out of psychosis. This may be painful for patients due to the realisation and facing of difficulties. The aim of professionals is to facilitate this process for the patient and guide him/her by acknowledging that the person's explanatory framework may be different from that of the professional's as seen in the following service user narrative presented by Romme (2007):

Every time, when I was released from hospital and went back to normal life, there was this reduction of possibilities in my life. Nearly ten years later I was not interested in anything anymore. It took me quite a while to see the relationship between my voices and my life, so I realized that when I was angry and did not express my anger the voices became angry at me (sec. 3-4).

This approach is synonymous with the *Hearing Voices Network*, originally founded by Marius Romme in the Netherlands and which has been developed in other

countries such as the UK. These movements are concerned with the normalisation rather than the medicalization of the psychotic experience and are active in raising awareness of alternative ways of coping: “So, accepting is not concretely accepting everything of the voices as they are perceived, but is the beginning of looking differently at them; normalising them; being with many others who hear voices; creating hope and opening personal possibilities” (Romme, 2007, sec.3).

A similar approach is advocated by psychologist Rufus May whose main focus is to introduce alternatives to medical labelling and management of psychiatric symptoms, particularly, psychosis. In the documentary *The Doctor who Hears Voices* produced by Wade (2008), May provided an overview of the voice dialogue technique that can be used to engage in a therapeutic relationship with a person who is experiencing auditory command hallucinations. He explained that “supporting people in a force free way through their spiritual and emotional crises takes resources. Not more resources, just a different emphasis in how they are used.” (May, 2005, para.21). Such symptoms would normally probably merit an admission to a psychiatric hospital if a mainstream approach was to be applied:

In terms of care for psychosis, force is at the centre of the state’s approach to treatment. Neuroleptic drug treatment (under the pseudonym anti-psychotic medication) is presented as the treatment of choice for people with unusual beliefs behaviours or experiences; Treatment of choice for those who have no choice. Most first admissions to psychiatric hospital are characterised by a ‘try this medication or if you don’t we’ll have to force you to take it’ approach. Maybe we should rename mental health services ‘psychiatric drugging services’! (May, 2005, para.18).

Other leading figures in this area are Sandra Escher (See Escher, Delespaul, Romme, Buiks & Van Os, 2003) who has worked with Marius Romme to produce various publications, Pat Deegan (See Deegan, 2007), Tamsin Knight (See Knight, 2006) and Peter Lehmann (See Lehmann, 2009).

Bracken et al. (2012) noted that these controversial approaches may bring about changes in the way that psychiatrists and other professionals are trained since it seems as if the only skill that is needed to engage with psychiatric patients is willingness to listen and to respect the individual (p.432). One of the most powerful

contemporary movements, which may be viewed as lying midway between the critical psychiatry model and conventional psychiatry is the *Recovery Model*. Warner (2010) explained that this refers to a focus on self-determination, empowerment and interpersonal support – a focus on collaboration rather than adherence and compliance (p.3). Lieberman et al. (2008) added that educational programmes as well as structures such as user-run services and peer support are important concepts in the recovery model, which is a bio-psycho-social-spiritual model of care (p.487). As stated by Deegan (1996):

The recovery model is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings. Those of us who have been diagnosed are not objects to be acted upon. We are fully human subjects who can act and in acting, change our situation. We are human beings and we can speak for ourselves. We have a voice and can learn to use it. We have the right to be heard and listened to. We can become self-determining. We can take a stand toward what is distressing to us and need not be passive victims of an illness. We can become experts in our own journey of recovery (p.92).

#### **(iv). The constitution of evidence**

On reflection, it appears as if the alternative approaches to biomedical psychiatry that have just been described may add an interesting tangent to the range of psychiatric services and treatment options available in the twenty first century. However, there seems to be a paucity in the empirical evidence base related to a number of these approaches especially when compared to mainstream treatment options such as pharmacotherapy and psychotherapy. Interestingly, it also appears as if in cases where empirical research was in fact carried out, a naturalistic approach tended to be favoured over positivist research that features clinical trials and statistical data. This leads me to wonder about what determines the decision to consider a piece of information as evidence. The quest for evidence-based medicine originated from the need to close the gap between practice and research. More importantly, a parallel goal was the generation of proof that would inform practice, allow evaluation and dictate which approaches are effective and therefore encouraged (Eddy, 2005, p.16). In the same manner, practices that are not characterised by sufficient evidence in terms of effectiveness may be harder to justify and to fund (Children's Services Council, 2007, p.1). I do not perceive the

move towards research based interventions to be problematic. In contrast, a medical field which is only based on opinions may lead to dangerous practice and a return to the dark ages of inhumane and bizarre treatment. However, I cannot fail to note that in an effort to delineate safe and effective practice, most ethics committees and clinical excellence reviewers seem to regard specific types of research designs as being the gold standard in the generation of evidence. In terms of medications and interventions, meta-analyses of triple-blind randomized controlled trials (with concealment of allocation and low attrition) are commonly placed on top of the hierarchy of evidence whilst naturalistic and anecdotal research may be placed at lower levels (Guyatt, Sackett, Sinclair, Hayward, Cook & Cook, 1995, p.1802). This is where I question the validity of considering any particular evidence-type as the sole dictator of effectiveness of treatment.

Moncrieff and Timimi (2013) explored the dilemma of the validity of empirical positivist research in great detail by an analysis of NICE guidelines on Attention Deficit Hyperactivity Disorder (ADHD) and depression. The authors referred to the evidence base of clinical trials that informed these guidelines – studies that may be characterised by a number of limitations such as publication bias, conflict of interest by authors, incomplete information and other methodological problems:

NICE guidelines are not unbiased, value-free accounts that arise unaided from the data. They represent a particular position rooted in a technological understanding of the problems concerned, a position that guided and shaped the selection and interpretation of evidence and excluded or ignored evidence that was contradictory (Moncrieff & Timimi, 2013, p.68).

Moncrieff and Timimi (2013) added that this psychiatric knowledge seems to be contaminated with third party interests and power dynamics and in this sense, this resembles a Foucauldian knowledge-power symbiosis: “the authority of medicine operates to promote a technological view of the nature of certain human problems, which in turn strengthens medical hegemony over these areas” (p.60).

Thomas, Bracken and Timimi (2012) expressed similar views about the concept of Evidence Based Medicine, which they defined as “an attempt to identify the most successful technical interventions for discretely defined medical conditions” (p.295).

In their article, the authors' main focus was on exploring the interpretation (or misinterpretation) of findings from positivist research as well as the use of these interpretations in guiding treatment. As an example, the authors explored the pharmacological treatment and psychotherapeutic approaches used in depression. Consequently, they reached similar conclusions to Moncrieff and Timimi (2013): in relation to anti-depressants, the authors noted that in the majority of clinical trials carried out, placebo has been shown to be effective in alleviating symptoms. Similarly, in psychotherapy, it seems as if it is quality of the therapeutic alliance that influences outcomes rather than the specific type of therapy that is used. To this extent the authors described how research has indicated that the quality of the therapeutic alliance has been shown to be "up to seven times more influential in promoting change than treatment model" (Thomas et al., 2012, p.299). In relation to these findings, the authors claimed that this highlights the importance of respecting the patient's values and preferences rather than rigidly adhering to one professional approach and using it to steer the alliance. Furthermore, the complexity and diversity of human needs may also call for the incorporation of rationalism – a perspective that is often shunned by empirical research (Thomas et al., 2012, p.305).

Whilst sympathising with the arguments presented by Thomas et al. (2012), I have an additional difficulty which is that of the seemingly accepted definition of the term *Evidence Based Model*. This is due to the fact that in the medical world, there often seems to be the automatic right to equate the term *evidence* with a number of criteria that are mostly based on positivism – a practice that seems to characterise the Evidence Based Model. In my opinion, this feels like the act of hijacking of what would have otherwise been a more comprehensive term. My perception is similar to that presented by Hjørland (2011) who concluded that:

Given this one-sidedness of EBP, it would be better to speak of research-based practice (RBP), because no such one-sidedness is connected with this term. I suggest that EBP should be understood as the tradition in which a fixed hierarchy of research methods is applied in research synthesis and in guidelines for decisions for practitioners (p.1308).

Whilst agreeing with most of Hjørland's arguments against the one-sidedness of the Evidence Based Model, I do not subscribe to using *research-based practice* as a new

term. This is because this may act as an acceptance that the term *evidence* is indeed synonymous to positivist research to such an extent that a new term - *research-based practice* - had to be invented so as to enhance the significance of naturalistic research and rationalism. In my opinion, the term *evidence based practice* can still be used but an effort needs to be made to reverse the restriction of its definition to positivist research. This is not to imply that empirical research, in particular positivist research, should be debunked. In contrast, my contention is that there is a need for both interpretivist and positivist types of empirical research as well as knowledge arising from rationalism since ascribing to a sole type of approach may not be in the best interest of the service user: “The need to encompass evidence not only of effectiveness, but also of feasibility, appropriateness, and meaningfulness in order to achieve evidence-based healthcare practice” (Pearson, Wiechula, Court & Lockwood, 2007, p.88).

#### **2.3.4 Societal control, labelling, psychiatric power and third party interests**

The final section in this part of the review addresses political issues with relevance to the mesh of societal control and third party interests in the psychiatric discipline. This exploration is undertaken by reference to the works of key figures such as Szasz, Laing, Basaglia and Foucault.

Pilgrim and Rogers (2005) described how the relationship between psychiatry and social science has been characterised by a longstanding tension during the past half-century. The main stereotypical distinctions lie in the tendency to adhere to the medical model (focusing on individual physiological dysfunction) and the social care model (which is based on acknowledging the root of the problem as being social causes and consequences whilst affording focus on the individual’s phenomenology) (Middleton & Shaw, 2007, p.291).

Reference to the medical model and societal effects was also made by Szasz (1974b) who, in his book *Ceremonial Chemistry*, illustrated how the historical witches and gypsies were today’s drug addicts and insane people – the scapegoats of society (p.xv). He elaborated on the fact that society has a compulsive need to medicalise

and label challenging behaviour, as has happened in the case of obesity or as it is medically known, “hypernutrition” – a category created by medicine for those who have the wrong weight. This classification is similar to the concept of “drogophobia”, which involves a specialisation dealing with “substance misuse” – a medical label for those who take the wrong drugs:

The manufacture of the drug problem does, however, generate certain phenomena which could be discussed and dealt with in a number of ways. Many of these phenomena – especially the prohibition of certain substances called “dangerous drugs” and their use called ‘drug use’ or “drug addiction” – are now discussed in textbooks of pharmacology. This is as if the use of holy water were discussed in textbooks of inorganic chemistry. For if the study of drug addiction belongs to pharmacology because addiction has to do with drugs, then the study of baptism belongs to inorganic chemistry because this ceremony has to do with water (Szasz, 1974b, p.xvi).

In a similar manner to Pilgrim and Rogers (2005), Szasz’s line of thought traced the creation of psychiatry as a form of control for those who deviated from normal social behaviour. Amongst Szasz’s central arguments lies the individual’s right to commit suicide (Szasz, 2006), the abolition of court insanity testaments as a circumvention of punishment and the coercion related to involuntary hospitalisation (Szasz, 1998).

With a less radical approach than Szasz, Italian psychiatrist Basaglia shared the view that mental illness and diagnosis are linked to societal control (Basaglia, 1968). However, he did recognise and outline the role of the medical profession in addressing these symptoms. As a starting point, Basaglia (1964) recognised that many of the characteristics of mental illness that he observed in his patients seemed to subside as soon as they left from the asylum. From these observations, Basaglia (1964) concluded that the culture of the asylum was limiting our knowledge on mental illness and on the consequences of individuals suffering from these ailments (p.5). He was concerned that unless asylums were closed down, the culture within these settings would be unknowingly reconstructed by mental health professionals in community services. In his view, as long as confinement remained a possibility, professionals would continue to embrace the self-perception of being the responsible and knowledgeable entity and patients’ freedom would still be controlled by the doctor. Basaglia (1979) considered mental illness as the product of societal



exclusion. He deemed that psychiatry was the provider of scientific support for societal control:

I said I do not know what madness is. It can be all or nothing. It is a human condition. In our world, madness exists and is present as is reason. The problem is that society, to be called civil, should accept madness as it accepts reason. Instead, this society recognizes madness as part of reason, and a science that is responsible for unreason. The asylum has its reason to be, because it makes the rational irrational. When someone is crazy and goes into an insane asylum, he ceases to be crazy and becomes ill (Basaglia, 1979, p.18).

This line of thought may resemble that of Laing's, whose ideas, as based on the works of Marx and Sartre, viewed society as being the culprit of shackling the individual unwillingly and limiting his/her freedom (Laing, 1960). In this manner, individuals who are labelled as being mentally ill are just healthy people who have deviated from their natural state and are trying to return back to it. Huddleston (2006) noted a clear trend in Laing's writings in that he depicted his existential quest to challenge dictated definitions of normality (sec.3). Using his personal and clinical experience, children's stories and other literature, Laing illustrated how reality and normality are created by authority figures who in turn judge others who do not conform to this picture. In an attempt to question the concept of normality, Laing (1967) presented a series of reflections such as the sanity of supposedly 'normal' men who have killed others during justified acts of violence such as wars (p.64). It has to be noted that Laing could afford to understand and portray an insider perspective of the world of schizophrenia since he was a sufferer himself. Moreover his contributions paved the way for the concept of recovery as based on his articulation that symptoms of mental illness are often transient. This implies that with the appropriate support, an individual can gain insight of his place in the world and attain a higher level of existence (Kallista, 2004, p.1).

During the twentieth-century, sociologists such as Thomas Scheff and Erving Goffman worked in a parallel manner to the critical psychiatry movement in their quest to explore hazardous power issues in society. In 1966, the *Labelling Theory* was first applied to psychiatry in Scheff's book: *Being Mentally Ill: A Sociological Theory*. In this publication, Scheff (1966) challenged the accepted perceptions of

mental illness by arguing that these disorders are manifested through the effect of the influence and power exerted by society on individuals (p.44). In a similar way to that portrayed earlier by Goffman, Scheff (1966) discussed how society draws a perimeter around that which is considered as normal and views anything outside this boundary as being deviant or mentally abnormal (p.54). As a consequence, subtle pressure is placed on the individuals exhibiting this behaviour and gradually, they are guided into joining the mainstream population by modifying their undesirable behaviour. In this manner, Scheff concluded that a diagnosis of mental illness simply reflects that society does not accept a certain behaviour and has thus labelled it as unacceptable and treatable.

Becker's work is also consistent with this view. In his book *Outsiders*, Becker (1991) provided a fictitious example of a boy who was falsely accused and classified as a delinquent simply because he happened to be near a delinquent group (p.21). This illustrated the main principle of the Labelling Theory: "it's not what you do, but how others define you that makes you socially deviant" (Orcutt, 2012, Unit 6).

On reflecting on Scheff's main contentions, it may be noted that the hazardous power of societal control may be a reality which is often taken for granted. However I feel that an important point may be missing here in that sometimes, individuals who are experiencing symptoms akin to those described in a diagnosis of mental illness, may not be showing any deviant behaviour or experiencing any feelings of imposition by society. As a practical example, the concept of smiling depression is nowadays gaining recognition although it has not yet been attributed to a formal diagnosis in diagnostic manuals. This refers to a person who is experiencing prolonged overwhelming feelings of sadness but manages to contain these behind a smiling and perfectly functioning appearance (Labeaune, 2012). In this case, the behaviour of this person may remain undetected and it is usually not considered as deviant or overtly disruptive to the rest of society. This means that society does not attach a label to this individual or attempt to impose any compulsory treatment onto him. However, this person may still need help and the rationale behind the need for support is not related to society's need to control his/her behaviour but to the person's need to enhance his/her life quality.

The role of societal power is an essential theme throughout the most cited psychiatric discourse and has been particularly influenced by Michel Foucault. In *Madness and Civilization*, Foucault (1961/2001) explored the dynamic relationship between madness and unreason, which are both viewed as irregular and abnormal states (p.73). Historically, these conditions were attributed to the lower class citizens of society who were perceived as being odd by society but who were not necessarily inherently odd. At this instance, Foucault (1961/2001) alleged that a split was evident between unreason and madness. Unreason, which exhibited itself through crimes and pornography, was hidden away by society, as a protection for that very same society (p.74). On the other hand, madness was allowed and indeed encouraged to become visible so that it could be observed: “Madness had become a thing to look at: no longer a monster inside oneself, but an animal with strange mechanisms, a bestiality from which man had long since been suppressed” Foucault (1961/2001, p.66). Foucault noted that the process of observation served as a form of control – a theme that runs through the philosopher’s later work. The relationship between observation and control allowed the parameters of normality to be established and this in turn allowed the imposition of rules and violence onto the mad man/woman in order to set him/her into place:

Sufferers were generally chained to the walls and to beds. At Bethlehem, violent madwomen were chained by the ankles to the wall of a long gallery; their only garment was a homespun dress. At another hospital, in Benthall Green, a woman subject to violent seizures was placed in a pigsty, feet and fists bound (Foucault, 1961/2001, p.67).

In a narrated journey through historical epochs, Foucault traced the history of madness through three periods: the *Renaissance*, the *Classical Age* (the later seventeenth and most of the eighteenth centuries) and the *Modern Era*. One notable observation portrayed by Foucault (1961/2001) is that when leprosy disappeared, a societal vacuum was created – this vacuum can be interpreted as a space that society needs to fill with a condition that merits social exclusion (p.5). In this case, madness occupied this available void, or rather brought about a shift from a focus on a diseased body, as in the case of the leper, to emphasis on the abnormal mind. Foucault then introduced the Renaissance period. During this era, madness was perceived as a source of wisdom, which delineated worldly limits and which was

presented in literature as the difference between what man really is and what he pretends to be (Foucault, 1961/2001, p.21). During the Enlightenment, a sharp distinction between rationality and irrationality was made. Another distinction was also made between unreason due to madness and that originating from other sources:

We can see why the scandal of madness could be exalted, while that of the other forms of unreason was concealed with so much care. The scandal of unreason produced only the contagious example of transgression and immorality; the scandal of madness showed men how close to animality their Fall could bring them (Foucault, 1961/2001, p.76/77).

In the modern world, unreason is still not allowed to be present at the surface societal level and is only understandable through art (Foucault, 1961/2001, p.272). Contrastingly, madness, as a separate concept, has been adopted by the medical field and is controlled by the experts in this discipline. The appearance of the doctor figure – the psychiatrist – supported this new system of observation and repression. In this way, madness was adopted by the medical discipline and the authority of scientific knowledge backed any decisions and actions (Foucault, 1961/2001, p.261). This added power to the discipline until nowadays, this power is almost regarded as an automatic professional right. Foucault's exploration of the knowledge and power issues in the field of psychiatry runs through the therapeutic alliance between the professional and the patient and the exchange of knowledge and power in this microsystem:

As positivism imposes itself upon medicine and psychiatry, this practice becomes more and more obscure, the psychiatrist's power more and more miraculous, and the doctor-patient couple sinks deeper into a strange world. In the patient's eyes, the doctor becomes a thaumaturge: the authority he has borrowed from order, morality...it is because he is a doctor that he is believed to possess these powers (Foucault, 1961/2001, p.261).

Foucault's genealogy led to his insistence that madness is neither natural nor static. This is because it depends on the meaning attributed to it by the society within which it exists. As evidenced through the passage of time, madness and unreason were characterised by diverse and at times, even opposing, facets. For instance, in one era, madness and unreason were perceived as being related whilst in another, they were distinguished from one another. On the same note, madness was at times considered

to be shameful whereas during other periods, it was prompted to the forefront. The same opposing views characterise the asylum whose function has ranged from separation and discipline to healing and rehabilitation.

This can be attributed to the concept of discourse which is one of the major themes in most of Foucault's works. Discourse refers to a system of knowledge that dominates truth, morality, meaning and normality: "systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak" (Lessa, 2006, p.285). Foucault's quest was to explore the various factors that influenced the discourse on madness and its construction.

In a similar manner to Foucault, Coulter (1979) contended that the label of insanity is assigned when an individual's behaviour steps beyond social norms rather than when a pathological pattern is scientifically identified. He argued that the body of normality is controlled by social groups and that this may be problematic since in contrast to scientific evidence, subjective judgments are context-dependent. In order to delineate his argument, Coulter proceeded to say that in fact, oftentimes, ascriptions of psychiatric behaviour is often made by the individual himself or by his social network - this usually happens much before psychiatric support is elicited. Coulter (1979) used this example to indicate that the psychiatrist's diagnosis is thus a label attached to that type of behaviour that has already been viewed as problematic: "[a] response to mundane social and moral requirements, and not to the development of some esoteric branch of knowledge" (p.147).

A counter argument to Coulter's view may compare his example to symptoms related to a general medical problem, such as a cardiac problem. In a similar manner to the situation recounted by Coulter, a person who is experiencing symptoms related to a cardiac problem, for instance, shortness of breath, may often conclude that his/her symptom is problematic. This view may also be shared by his/her social network. This takes place *a priori* a pathological diagnosis by a cardiac specialist. Thus, in the same way as in psychiatry, the specialist's diagnosis is also merely a label placed onto a problematic symptom. Thus, it seems as if irrelevant of whether a

symptom or behaviour has a scientific or a societal basis or not, diagnosis always constitutes the application of a label. As already discussed in an earlier part of this review, this may not be necessarily linked to negative consequences and in fact, at times it may provide relief for the individual. By the term relief, I am referring to that comfort that may be found when one is given a name and a meaning for his/her symptoms thus showing him/her that the symptoms are known, explainable and may even be treated.

However, to me, the main ethical problems arise in relation to what happens after a diagnosis is made. This is because in a contrasting way to general medicine, psychiatry has been provided with the power to control its patient and restrict his/her freedom. Ingleby (1981) asserted that the problem with a psychiatric diagnosis is that by allowing a particular behaviour to be construed within a medical framework, the individual is subjected to the disorder management package which forms part of that framework (p.23). In Ingleby's opinion, this is erroneous because psychiatric treatment and psychiatry are based on positivism and so cultural judgements related to health or illness are presented, perhaps mistakenly, as empirical truths (Ingleby, 1981, p.24).

### **2.3.5 Conclusion**

As we entered the "Decade of the Brain" (Jones & Lorne, 1999, p.739), the debates on the mental health field continued to shape the discourse that characterises this area. During this second part of the review, an attempt was made to address the major themes of discourse pertaining to mental health. In my view, the discourses explored ranged from the strangely simplistic to those which are highly methodical and complex. Echoing Foucault's contentions, I feel that this combination of discourses may be that which ultimately influences the basic nature of the therapeutic alliance - the way in which different forms of knowledge and power are embedded in each of the singular bonds formed between each professional and the person who is receiving care. This leads to the final part of this review which is a concluding exploration of the origins and characteristics of the alliance, as explored in view of the concepts that have been examined so far.

## **2.4 The therapeutic alliance**

### **2.4.1 Introduction**

*I walk into the brightly lit waiting area and sit on one of the chairs as my eyes wander to the firmly closed door. The label reads your name and lists your qualifications – they look alien to me but at the same time, they also make me feel safe – as if they are telling me: “You are doing the right thing, you are seeking professional help”.*

*But then again, I wonder. I have no doubt that you have the ability to give a meaning to my feelings, to my disturbing thoughts and to my behaviour. Yet, is it possible to fit me and my baggage in a standard box that you fit other patients in? This is ME, my whole life, my choices, my successes, my failures, my ideas. I need to share a whole life story with you so that you may get to know me as much as I know myself. I chuckle as I realise that the idea that I have verges on the absurd – I am asking for a therapist who can become ‘me’ and then merge that knowledge about myself with his skills. As the door opens and I stand up, I instantly forget the introductory speech that I had prepared for this first session. “Have a seat”, you say, and our journey begins.*

Author’s own

This part of the review has been divided into three sections. The first section explores the concept of the therapeutic alliance in healthcare professions as well as its history. The second section is dedicated to a review of research that has been carried out in relation to care receiver and care provider characteristics in the alliance concluding in a critical discussion about emotional and multiple intelligences as applied to healthcare. The third section builds upon previous parts in the literature review in relation to the knowledge-power symbiosis within the therapeutic alliance.

### **2.4.2 The therapeutic alliance: an overview of a concept**

At times they are called *patients* because they are in need of medical care. At others, they are referred to as *service users* or *clients* because professionals are offering a

service and these individuals are making use of it. During instances of reflection, the term *they* becomes *us* and then *we* speak about the statistical “one in four” chance of any individual suffering from a mental disorder during his lifetime (Alonso et al., 2004, p.21). Irrelevant of the nomenclature used, it is these individuals who form a vital part of the basic treatment modality in the mental health area – the therapeutic alliance - also known as the “helping alliance” or “working alliance” (Howgego, Yellowlees, Owen, Meldrum & Dark, 2003, p.170).

This section traces the origin of the therapeutic alliance as well as its changes through history. The concept of the therapeutic alliance is believed to have its roots within the Freudian school of thought, particularly in relation to the theory of transference (Howgego et al., 2003, p.171). Transference and countertransference, which typically refer to redirection of feelings between individuals in a therapeutic relationship, were originally perceived by Freud as being the patient’s resistance to therapy but later he asserted that “the transference, which, whether affectionate or hostile, seemed in every case to constitute the greatest threat to the treatment, becomes its best tool” (Freud, 1915/1989, p.496). Thus, it became more evident that if transference is managed in a professional manner, then it can serve as a powerful vehicle in engaging with individuals who are seeking care.

Rogers (1961) proposed three fundamental constructs of the therapeutic alliance, these being empathy, unconditional positive regard and congruence (p.285). He also devoted effort to identifying the role of the therapist in the relationship – he contended that the primary value of the professional is that of providing a “scaffolding” structure for the patient so that the latter could increase reflective capacity in a supported manner:

In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth? (Rogers, 1961, p.32).

In 1979, Bordin developed a working theory about the relationship and noted that the alliance involves three predominant phases: goal agreement, establishing tasks and



forming a positive bond between the professional and the client. Furthermore, the author elicited the importance of the patient's belief that the therapist is willing to support him/her. On the same lines, the therapist's confidence in the patient's ability to use his/her resources is equally essential. In this manner, the nature of the alliance influences therapy outcome, not because of specialised healing powers in its own right, but as a platform that supports the patient and that enhances his/her potential to accept treatment and believe in it (Bordin, 1979, p.252). This alternative definition is a divergence from the earlier dichotomy that featured an interdependent therapeutic process and intervention procedures.

Later, the alliance was portrayed by Hougaard (1994) as engaging two mutual and complementary concepts. The first component consists of an *alliance* which tends to be task-based. This entails a shared agreement regarding the purpose of the alliance as well as the goals to be set. The second concept is characterised by a *relationship* whereas a bond based on trust is formed between the client and the professional (p.67). This marked the difference between the *therapeutic alliance* and the *therapeutic relationship* – terms which are often used interchangeably but which are sometimes posited to be theoretically different. Baldwin, Wampold and Imel (2007) referred to the alliance as a part of the therapeutic relationship and described it as the mutual collaboration between the professional and the patient. Arising from a rather mystical and romantic origin, the therapeutic alliance has been well explored through multiple approaches incorporating positivist and interpretivist research methods. The consensus is that the alliance is statistically significant in influencing care outcome:

There is evidence that a positive therapeutic alliance is associated with better outcomes. The temporal relationship between alliance and symptomatic improvement is probably rather complex. However it seems reasonable to suggest that in the absence of a positive alliance, specific technical interventions are unlikely to be effective (Fonagy & Roth, 2005, p.131).

Evidence for this has been consistently presented in many research reports (See Fonagy & Roth, 2005; Orlinsky, Ronnestad & Willutzki, 2004; Duncan et al., 2003; Gaston, 1990). Exhaustive meta-analytic reviews such as that carried out by Martin, Gaske and Davis (2000) presented an important observation by noting that the positive effect of the alliance on care outcome is unaffected by the variables present

in the different studies explored (p.438). Neuroscience is similarly in accordance with this assertion: field findings have depicted higher neuro-plasticity in patients as a consequence of a positive relationship (e.g. Barletta & Fuller, 2002; Schore, 2002).

In a parallel manner to the psychological discipline, the therapeutic alliance has been of particular interest to several nursing researchers and authors. Amongst the most influential ones, extensive work was carried out by Peplau (1952), Forchuk (1995), Barker (2001) and Dziopa & Ahern (2009).

### **2.4.3 Personality characteristics and skills in the alliance**

This section explores literature that has been dedicated to care receiver and care provider characteristics in the alliance. This concerns a discussion of skills and personality traits as well as an exploration of the concepts of emotional and multiple intelligences as applied to healthcare.

#### **(i). Carer and patient characteristics**

A multitude of studies have explored the variables that are pertinent to the formation of an effective therapeutic alliance (Norcross, 2002; Hersoug, Hoglend, Monsen & Havik, 2001). Ackerman and Hilsenroth (2003) as well as Dziopa and Ahern (2009) identified a number of specific qualities that may enhance the bond between the professional and the patient. Amongst the comprehensive list found in their respective articles, notable care provider traits such as understanding and empathy, genuineness, dependability, benevolence, responsiveness, and self-awareness were predominant. In their conclusion, Dziopa and Ahern (2009) identified an interesting finding where they postulated that some of the therapeutic relationship attributes that were indicated were self-contradictory. In order to exemplify their point, they cited Scanlon (2006) who noted that in the process of being *non-judgmental*, nurses may not be *genuine* as they are sacrificing their own beliefs (Dziopa & Ahern, 2009, sec.13). Certain care provider characteristics may also have a negative impact on the therapeutic alliance (e.g. rigidity, criticalness, inappropriate self-disclosure: see Verhaagen, 2010, p.45).

Since the care receiver is the other important entity in the working alliance, it may be naturally assumed that there is a counterpart body of research that has been devoted to elicit the care receiver characteristics that may play an influential role in the alliance. In fact, prominent research such as that by Boswell et al. (2013) and Smith-Hansen (2008) has depicted clusters of patient characteristics and behaviour such as openness to discuss problems, predisposition to change and motivation. However it can be noted that studies that have endeavoured to explore the care receiver side of this subject are limited in number. It is felt that this indicates a vital research gap that needs to be addressed in an era where the patient needs to be perceived as an important stakeholder in care.

On revisiting the care provider characteristics that have been identified as affecting the nature of the alliance, it can be noted that in my opinion, most of the qualities may not necessarily be related to the professional's perceived knowledge, expertise and amount of qualifications. This is in disagreement with one of the conclusions made by Dziopa and Ahern (2009):

The ability to understand a patient's needs from non-verbal cues and to ascribe meanings to behaviours requires the sophisticated skill of the advanced practice psychiatric/ mental health nurse. Furthermore, the interface of certain attributes with others requires the psychiatric/ mental health nurse to have specialized skills (sec.13).

Here I am not negating the importance and value of training and the practice of advanced learning skills – if I were to do that, I would be carrying out a self-disservice since I am a mental health nursing lecturer. My point is that claims such as the one presented by Dziopa and Ahern (2009) may be overinflating and mystifying the importance of advanced “sophisticated” and “specialised” skills. This is because I feel that the main player in the picture is probably emotional intelligence and its various constituents. In this regard, I believe that Goleman's ideas may offer valuable guidance: “A prerequisite to empathy is simply paying attention to the person in pain” (Goleman, 2013, para.5). In this excerpt from Goleman's work, the correlation and similarity between *empathy* (which is often regarded as an academic skill) and the layman behaviour of *simply paying attention* (which is a non-specialist and non-advanced skill) can be noted.

This line of thought is supported by a number of theorists and researchers who endeavoured to apply the principles of the *Emotional Intelligence Theory* to the therapeutic alliance (Pearson, 2011, p.1). It is felt that a brief stroll through the main tenets of this work may be useful and may provoke further reflection on the nature of the alliance concept.

## **ii). Emotional intelligence and multiple intelligences**

In his article about the effect of power in military mental health nursing relationships, Cole (2006) elaborated on the concept of emotional intelligence and the vital role that it plays in the therapeutic alliance. He cited classic work such as that by Goleman who authored *Emotional Intelligence* – a ground breaking publication that explored the role of emotional intelligence and its equal importance to conventional intelligence (IQ) (Cole, 2006, p.28). A brief review of emotional intelligence shows the origin of this term in the 1970s and 80s as illustrated by the writings of psychologists Gardner (1983) and Mayer & Salovey (1997). The tenets of the concept of emotional intelligence feature the theory that traditional intelligence constitutes only one part of the intelligence spectrum and other intelligence forms are equally required and vital for an individual's success. This implies that there is the need for an increased focus on behaviour and personality traits rather than a preoccupation with academic excellence only:

In the last decade or so, science has discovered a tremendous amount about the role emotions play in our lives. Researchers have found that even more than IQ, your emotional awareness and abilities to handle feelings will determine your success and happiness in all walks of life, including family relationships (Gottman & DeClaire, 1997, p.20).

The main argument in favour of the role of emotional intelligence is the knowledge that an individual who is brilliant in academia may not necessarily be similarly good in maintaining effective inter-personal interactions.

The four branch model of emotional intelligence as described by Mayer and Salovey (1997, p.10/11) defines emotional intelligence as the ability to:

- accurately perceive emotions in oneself and others
- use emotions to facilitate thinking
- understand emotional meanings
- manage emotions

The application of emotional intelligence to the therapeutic alliance has been discussed by Poullis (2007) who noted that there is a paucity of research that relates emotional intelligence to overarching issues in the subject of the therapeutic alliance (p.5). He subsequently explored how intelligence and emotions may feature in the development of the therapeutic relationship. Poullis (2007) elaborated on the competencies that may be needed by therapists in order to use emotions in an intelligent manner (p.5). He contended that the competencies identified are similar to those discussed by Goleman (2005) and Bar-On (1997) and include intrapersonal skills (e.g. self-awareness, self-regulation, stress management, adaptability, ability to manage heavy feelings and motivation) and interpersonal skills (e.g. empathy and social skills) (Poullis, 2007, p.110). In a similar exploration by Pearson (2011), the author's position went beyond that of abiding to only one type of intelligence, be it emotional intelligence or otherwise. Instead he contended that rather than the sole use of emotional intelligence or IQ, it would serve to reflect upon a pluralistic approach - the concept of *Multiple Intelligences (MI)* – an area that is predominant in Gardner's work (Pearson, 2011, p.2). It is worthwhile noting that whilst the *Multiple Intelligences Theory* was introduced within various disciplines over the last decade, it is still finding its way into adult counselling (Pearson, 2011, p.2). Importantly, the focus on multiple intelligences has been linked to favourable outcomes and in terms of the therapeutic alliance, it may enhance flexibility and better representation of the patient's preferences. At this point, it is worthwhile to revisit a contention made in an earlier part of this review, where it was stated that there seems to be general consensus that the therapeutic alliance provides the basic framework that determines care outcomes. Rivett (2008) noted that traditional research focused on comparing the effectiveness of psychological therapies and general meta-analytic results show that most approaches are equally effective. As a result, it is now being recommended that rather than religiously adhering to one therapy approach or practice, an eclectic use may be more appropriate.

Consequently, the current research trend has now shifted to exploring effective characteristics that form the denominator for therapy effectiveness across all approaches (Rivett, 2008, p.102). Pearson (2011) paid homage to this research and posited that the Multiple Intelligences Theory can be used as the theoretical underpinning – the denominator - for this integrated approach. He presented practical examples of how each intelligence type manifests in different therapies. A typical example is musical intelligence which, in the form of music therapy; may be ideal for those patients who show appreciation for music. Cognitive Behavioural Therapy is another widely used approach and one that can be linked to a care receiver's preference for logical/ mathematical intelligence (p.10). Knowing that MI is an area that can be enhanced by training, Pearson's recommendation for therapist training in the self-use and assessment of MI in therapy is felt to be an urgent need.

#### **2.4.4 Knowledge and power in the therapeutic alliance**

In this literature review, several sections have been dedicated to an exploration of the knowledge-power relationship in healthcare professions. These culminate in this final section which builds upon previous arguments and attempts to place the alliance within the knowledge-power nexus.

In one of his articles about power in psychotherapy and counselling, Zur (2009) noted that it seems as if the general consensus in the literature is that power in the therapeutic alliance is unidirectional and features a professional in control of a vulnerable patient (p.160). This perception is perpetuated by a number of factors, with the concept of transference being at the forefront. Zur (2009) added that the idea of a "slippery slope" and "power differential" has been another major contributor to the perception of power as being monolithic and held by the professional (p.161). He referred to the overemphasis on boundaries in therapy to such an extreme that natural and potentially therapeutic gestures such as touch, self-disclosure and gifts may be pictured as demonic and as leading to a slippery slope in the alliance:

This rather paranoid view asserts that due to the client's inability to resist their omnipotent therapists, a routine hug is likely to lead to sexual

relationships and a simple social encounter in the community to intricate relationships (Zur, 2009, p.161).

On sympathising with Zur's view, I feel that whilst at times, an activity may clearly indicate a boundary violation, at others it may not be so clear and perhaps not detrimental or even beneficial to the alliance. For instance, in certain circumstances, a degree of self-disclosure may be helpful especially in an alliance such as the therapeutic one, where the care receiver is expected to disclose personal and sensitive issues to a professional who may be no more than a stranger. Similarly, a hug may introduce elements of humanism and sympathy which may be useful during certain instances in therapy. The danger lies if one is not able to gauge the probable outcome of engaging in such activities during different situations. I believe that as a professional, this ability requires that which I call *professional common sense*, which arises from a combination of experience, professional knowledge and emotional or multiple intelligences.

Zur (2009) proceeded to discuss how in relation to the consensus on the presence of a power imbalance in the alliance, literature on the topic can be classified in three categories (p.161). One of these categories or approaches is composed by those who are highly critical of psychiatry and mental illness especially with regards to power abuse and negative consequences on service users. These views are consistent with those seen in the anti-psychiatry movement that has been described in an earlier part of this chapter. The second group of scholars who explored the power imbalance in the therapeutic alliance held that power is not necessarily abusive but warned that it can be detrimental if misused. Zur (2009) mentioned the works of Gutheil and Brodsky (2008), Celenza (2007) and Brown (1994) amongst examples of authors who presented this perception (p.161). Another group who contributed to literature related to the power imbalance in the alliance is composed of feminists, humanists, existentialists and postmodern academics. Their main efforts are dedicated to reducing the power imbalance in order to create therapeutic relationships that are egalitarian and mutually respectful. Moreover, they claim that negating the presence of a power differential in alliance is harmful and an act of denial. Sutherland (2007) and Proctor (2002) are some of the works cited by Zur (2009) as an example of this

type of approach (p.161). In an addition to works that feature this approach, I include the psychiatric nursing research carried out by Dziopa and Ahern (2009) in which the “promotion of equality” has been shown to be one of the prominent attributes of an effective therapeutic alliance. In their article, the authors initiated the discussion about this area by stating that the relationship between a psychiatric nurse and a patient is intrinsically imbalanced. This is supported by the fact that the “helper” role of the nurse is inherently linked to power (Dziopa & Ahern, 2009, sec.9). I view this quasi-assumption about the seemingly unavoidable existence of a power imbalance in the therapeutic alliance as being disturbing and questionable. It seems as if the suggestion here is that the natural state of the therapeutic alliance is characterised by a power imbalance. In line with this “natural” imbalance, Dziopa and her colleague elaborated on a number of power skills that the nurse has the right to use. These include “offering expert knowledge through teaching...‘mothering’ or protecting vulnerable patients, through actions such as disciplining medication compliance and making sure patients eat” (Dziopa & Ahern, 2009, sec.9).

Later on, the researcher clearly depicted the specific psychiatric nursing skills that facilitate equality in the relationship. These include “casual conversations, allowing time to inquire how patients are doing, creating the illusion of choice and allowing the patient to speak and to be heard” (Dziopa & Ahern, 2009, sec.9). Despite the benevolent intention of these listed activities, this perception of the nurse-patient alliance is felt to pose a major ethical and philosophical difficulty. At this point, my counterargument is that the natural state of the alliance does not need to constitute a power imbalance that the nurse attempts to amend by using special skills. Let us instead perceive this argument from a care receiver’s point of view. I cannot profess to knowing what it feels like to be a care receiver within a therapeutic alliance and even if I did, each individual is unique so generalizability is beyond the scope of this argument. However, it does seem that being a care receiver and knowing *a priori* that you are entering into an alliance which is naturally and inevitably characterised by a power imbalance may feel disempowering. It does point towards a helpless patient who is then at the mercy of the knowledgeable nurse. On referring back to approaches that supposedly diminish the power gap in the alliance, it may also be worthwhile to reflect on the discourse being used in the above excerpt by Dziopa and



her colleague. Wording used includes: “expert knowledge”, “teaching”, “mothering”, “compliance” and finally and perhaps the most controversial of all, at least to myself: the provision of an “illusion of choice” to the care receiver. As used in the latter example, the word “illusion”, which may be defined as “something that is not really what it seems to be” (Cambridge Dictionaries, 2014), instils a sense of apprehension in me. Consequently, I wonder why choice needs to be presented as an illusion because this seems as if the care receiver does not really have a choice but needs to be tricked into perceiving that s/he has a choice.

If this is the case, I feel that the advocacy for these approaches seems to counteract the rooting for a power balance as it is evident that the professional and his/her skills still constitute the major body of expertise in the alliance. Foucault (1961/ 2001) may have touched upon the concept of illusions when he described the dinner parties that Tuke (a philanthropist and mental-health reformer) used to hold for patients in his asylum. The aim of these parties was to provide the opportunity for the inmates to interact with ‘normal’ people in a setting of respect and etiquette (p.236). Foucault (1961/ 2001) described how despite the apparent therapeutic purpose of these parties, in reality, they did not do much for the “madman” as they were simply an illusion – a re-creation of a reality where the mad man was seen as being accepted and given choices: “It is the organisation around the mad man of a world where everything would be like and near him, but in which he himself would remain a stranger, the stranger *par excellence*” (p.237).

On reverting back to the article by Dziopa and Ahern (2009), it has to be acknowledged that the authors concluded their discussion by stating that equality is grounded in acknowledging that the patient and the nurse have equally important roles and knowledge-bodies (sec. 9). Still, some of the approaches mentioned earlier in the article may not be ideal suggestions for nurses as potential pitfalls may stem from such perceptions. My view is similar to that expressed by Zur (2009) who cautioned about the perception of an inherent “power differential” in the therapeutic alliance – a phenomenon which he perceives as being a misconception (p.160). He claimed that scholars have pictured the relationship between a care provider and a care receiver as a parent-child relationship, with the consequence of depicting the

client as helpless and vulnerable. In my view, some of the excerpts discussed from the study carried out Dziopa and Ahern (2009) seem to be an example of Zur's contention.

As already mentioned earlier, a modernist approach challenged the concept of an all-knowing professional and brought with it a shift to the other side of the pole by highlighting the need of the professional to deny his/her knowledge and acknowledge the patient as the only expert in the alliance – the expert by experience (Brown, 2007, p.4). The stance taken through this approach portrays power as being negative and repressive. In Foucauldian terms, this practice may not be effective because primarily, it functions on the premise that complete professional objectivity is desirable. This implies a perceived absence of power in the therapeutic alliance. According to Foucault (1978/1990), such a position is not possible because “there is no escaping power...it is always-ready present, constituting the very thing that one attempts to counter it with” (p.82).

Realistically, it is very likely that the application of a modernist approach to the therapeutic alliance may result in the very phenomenon described by Foucault. This is attributed to the fact that ironically, although a modernist view rebukes expert power, it does not succeed in eradicating its presence within the therapeutic alliance – it simply transfers it from one side of the equilibrium (the care provider side) to the other (the care receiver domain). It is thus clear that power is still present in the alliance – it has simply shifted poles. Here I argue that the request for a power shift by the modernist is neither justified nor ethical. My view is concurrent with that of Zur's (2009) who elaborated on the fact that clients come in all shapes and sizes and it is erroneous to assume that clients are always the underdogs in the alliance (p.161). He exemplified this by one of his personal experiences with a client:

One day she said to me: You shrinks seem to think you are these powerful beings. Your literature paints images of clients as helpless, vulnerable, pliable, weak creatures at the mercy of you omnipotent people. Well, let me tell you something about power. With my J.D. and Ph.D., I am better educated than you are, which gives me more power than you have with your Ph.D. I am an attractive woman, which gives me the undeniable power that

sexy women have over men. So much for your illusion of power (Zur, 2009, p.161).

In view of this example, the author urged for the exploration of knowledge and power in therapeutic alliances to move beyond a view of power as being rigid and in the hands of a professional because the presence of a power differential may not always be the case. In a recent publication, Zur (2014) exemplified this by identifying various ways of how knowledge and power may manifest both on the care receiver's side as well as on the care provider's side of the therapeutic alliance (sec.5). As a summary of his ideas, the care provider's knowledge and power may be brought about by the following:

- Expert-knowledge power e.g. through experience in the professional field and training – “Aesculapian power” (Brody, 1992, p.16)
- Power arising from societal respect for the healer's role
- Positional power: setting the time and place for therapy, setting the stage such as the seating arrangement, the right to ask questions but not necessarily answer questions, the act of not disclosing personal information to the service user, the act of diagnosing and forcing hospitalisation and the authority to determine the rules of the relationship
- Reward power related to some care receivers' need for their carer's approval and to the carer's ability to give permissions and rewards e.g. a nurse can report that a hospitalised patient's behaviour has improved which may lead the doctor to grant the patient permission to leave from the hospital
- The use of professional jargon and the ability to describe the care receiver's behaviour by terms like “resistance to treatment” (implying placement of blame on the care receiver for ineffectiveness of the alliance). Note: Here I also add another term: “insight” (indicating a care receiver's readiness to accept a diagnostic label and professional help)

Similarly, knowledge and power on behalf of the care receiver may manifest as follows:

- Expert-knowledge power e.g. through self-experience and general knowledge
- Positional power: time control (arriving late or early for a session), space control (sitting too close or too far away from the therapist), decision to answer or refuse to answer questions as well as answering them truthfully or untruthfully, the use of fear e.g. by service users who have a history of being violent and who may attempt to instil fear in therapists, sexual seduction and legal violation e.g. false accusations
- The choice to talk or to remain silent
- Use of language e.g. violent, vulgar or threatening language
- Dominating the conversation
- Inappropriate gifts or incentives
- Making enquiries about therapist
- Reward power related to a therapist's seek for client approval and job satisfaction

On a similar note, Brown (2007) argued that an alliance constituting an “all-knowing’ side and a “no-knowing” side may not be beneficial for the future of the therapeutic alliance in mental health services (p.8). Hence, asking the professional to denounce knowledge and power in an attempt to balance power in alliances may not be fruitful just as much as it is not fruitful to consider the care receiver as being powerless (Brown, 2007, p.12). The author cited White (1994) in her conclusion that such a stance implies an attempt to escape power and simultaneously risking the

assumption of a comfortable passive professional position that may jeopardise the framework of the therapeutic alliance. Here it can also be acknowledged that expecting the professional to deny his expertise may be rather disempowering and probably unethical for the professional in question. Instead, in a similar way to Zur (2009, p.163), the author predicated that a modernist-postmodernist merge that claims “partial-knowing” may be a more appropriate tool kit for the mental health discipline (Brown, 2007, p.12). The argument culminated in the question of how this principle can be applied in practice. Brown’s answer featured the unpacking and re-authoring of patients’ narratives in order to unearth oppressive dominant discourses which are often internalised and lead to resistance (Brown, 2007, p.11). As acknowledged by the author, this is different than the approach advocated by Anderson and Goolishian (1992) who cautioned against a professional attempt to re-write patients’ stories because it is only the patient who is the master story teller.

#### **2.4.5 Conclusion**

This final part in the review has been directed at the focal subject area of this study, specifically the knowledge and power constructs in the therapeutic alliance between the service provider and the receiver. Literature related to research about the alliance was cited in order to attempt to understand the origin, meaning, necessity and structure of the therapeutic alliance as well as challenges related to its composition and outcomes. In conjunction with the other two parts of this review, it is hoped that this part will enrich my study by facilitating the discussion of my findings in light of the existing literature about the knowledge-power interface in the therapeutic alliance.

## 2.5 Chapter conclusion

The process of carrying out a review of prominent literature surrounding the area of interest has felt akin to peeling the layers of an onion. In the same token, all of the concepts that have been examined in the review have added a piece to the jigsaw puzzle that totals as the therapeutic alliance picture. In true Foucauldian nature, this resembles a quest which does not attempt to arrive at one definite truth. Indeed, as it has been emphasised throughout the review, the controversial debates that surround the mental health field are in fact based on the simple concept that different entities attribute different meanings to *truth*. At this point, it would be difficult to ascertain whether there is one single truth that has yet to be attained. However, what can be realised without a shadow of a doubt is that even if there is one truth, this only guarantees that it will be perceived in a multitude of ways by different entities. As a concluding note, this is why this journey was not particularly concerned with validating different perceptions of truth. On the contrary, the preoccupation of this study is to understand circumstances and discourses that may lead to various perceptions of truth and the manner that these are managed when they translate to knowledge and power.

In this light, the main research question guiding this study was:

**What is the nature of the combination of knowledge and power in therapeutic alliances in a mental health in-patient setting in Malta?**

This was accompanied by two sub-questions, namely:

**What role do dominant discourses play in the positions occupied by care providers and care receivers in therapeutic alliances in a mental health in-patient setting in Malta?**

**What type of knowledge is required by care providers and care receivers for power to be managed in a manner that may enhance therapeutic effects in this setting?**

## *Chapter 3*

# **METHOD**

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### **3.1 Chapter introduction**

Research evolves from an inherent human curiosity centering on the desire to gain knowledge about a phenomenon. As discussed in the previous chapter, the concept of knowledge is a multifactorial one with a myriad of views about its meaning and attainment. In a similar way, research methods are as diverse as the different approaches to knowledge and one's approach to setting and answering research questions may depend not only on the nature of the questions themselves but also on one's beliefs, knowledge, perception of events and personal characteristics. Hence, any particular research method offers one way, out of other possible ways, of revealing new knowledge - a step forward to getting closer to the truth as defined by that researcher. Hence, by relating to a particular formal paradigm, a researcher identifies himself/herself with a larger group of individuals who form a school of thought which encourages the use of a systematic and tested pattern to answer research questions (May, 2001, p.8).

### **3.2 The research method**

#### **3.2.1 Selection of research approach**

A broad based question related to a specific area is usually the first raw form of what would be gradually preened to a more specific inquisitive statement that identifies the phenomenon under study. If one were to use a funnel analogy, in my research process, the broader part of the funnel was practically occupied by my quest to explore the constructs of the balance of knowledge and power in the alliance between the care provider and the care receiver in psychiatry. In addition to this primary focal point, I also wished to explore the potential implications of these constructs to education, which is an area to which I can perhaps offer a direct contribution in view of my professional role in academia as well as my link with the clinical setting. This involved the exploration of the taught and experiential

knowledge required by both the care provider and care receiver in order for both parties to manage the knowledge-power balance in the therapeutic alliance in a manner that enhances the therapeutic effect. Graduating from the broader part of the funnel to its narrow neck requires the researcher to mould the multiple broad questions into a central structured one. This may then be followed by sub questions that include other key variables and the relationship between them, as advised by Creswell (2003, p.106). In my study, this process resulted in one central question and two sub-questions – these have been presented in the previous chapter.

The next step involved the selection of a methodological approach. At this stage, the guidance provided by Blaikie (2000) in asking oneself about the type of questions being set, proved valuable in identifying the *how*, *what* and *why* elements of my queries (p.61). On reflecting on the nature of these questions, I acknowledged the interpretivist undertones underlying the area of interest. Additionally, the literature search that I have undertaken, which was described in Chapter 2, has shown that the subject matter of this study remains to be further explored and may primarily require critical exploration, understanding and description. Hence, it would not be illogical to note that there seems to be a greater need to focus on induction and interpretation rather than on attempting to explore the subject in a quantitative and statistical manner, as typified by a positivist stance. I feel that the latter approach would have been limited in its potential to provide an in-depth answer to the research questions set. These reflections led to my decision to opt for a purely interpretivist approach.

I believe that in this study, the use of this approach has been beneficial in the exploration of general concepts as well as in the facilitation of the identification of patterns. It has also been useful in guiding me into a deeply focused and intense enquiry leading to a comprehensive description of the phenomenon under study. Whilst acknowledging the strength that this approach has added to my investigation, it is not to say that it was not characterised by any limitations. In fact, these will be duly identified and addressed in the concluding part of the thesis. In a concise and factual manner, Geertz (1973) outlined that which may still be one of the main challenges in interpretivist research, by asserting that “what we call our data are really our own constructions of other people’s constructions of what they and their compatriots are up to” (p.9). It is acknowledged that this detraction has invariably



featured in my study. In an attempt to partially address this challenge, as a researcher, I sought to continuously engage in mindfulness and reflexivity during the gathering, analysis and interpretation of data. Furthermore, following the interviews with the care receivers, transcripts were analysed by the participants so as to enhance the likelihood that what has been understood by the researcher actually reflected the perception of the participant at that particular point in time.

### 3.2.2 Selection of Foucauldian Discourse Analysis

The research questions, the objectives of the study and the literature revolving round the area of interest were integrated and themed by common underlying trends in the study. As contended by Willig and Stainton-Rogers (2008), reflexivity is a crucial dimension in interpretivist research (p.6). It is through the reflective process depicted in Figure 1 that the trends weaving themselves throughout the length of the area of interest could be extracted.

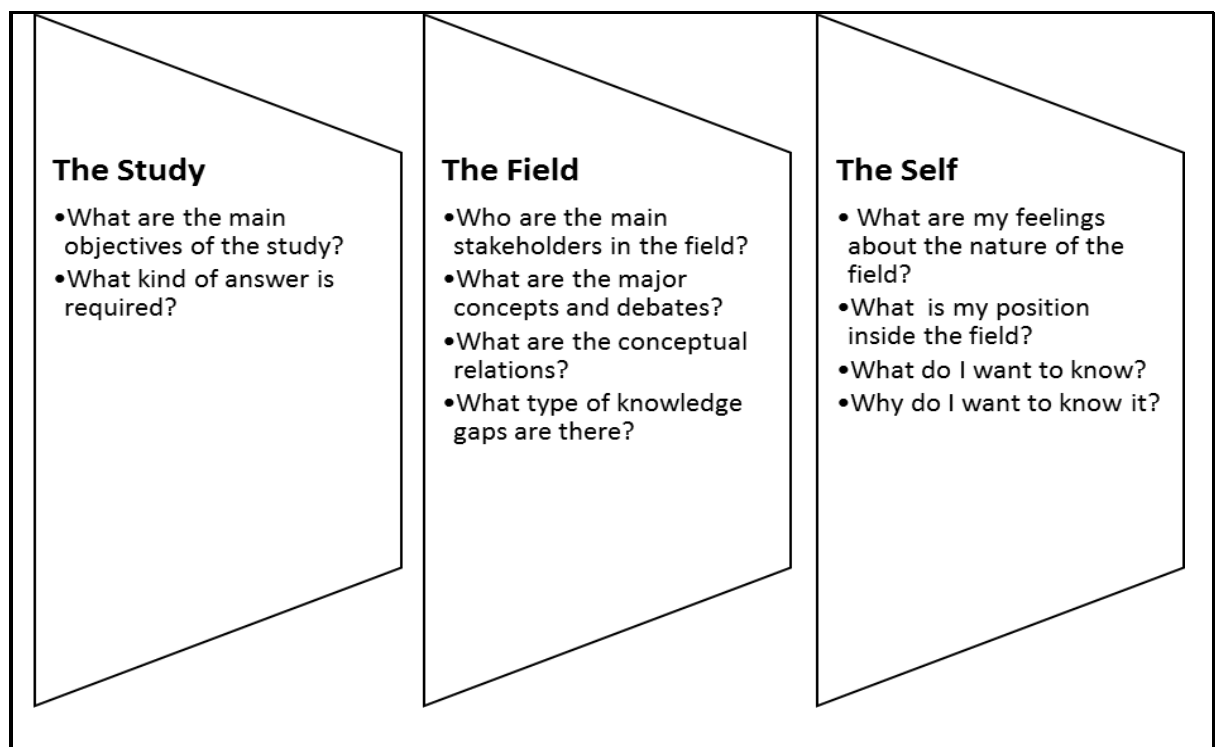


Figure 1: Steps guiding the reflective exercise (author's own)

Using discourse as a departure point, the interest in this particular study was not only to describe a reality but to additionally analyse and appraise the world that has been gradually constructed through discourse. Having in the first instance set my position of alignment with the interpretivist approach, several qualitative methods could have lent themselves to the investigation of this topic. Utilising a discourse analysis approach was probably an effective tool for critique in order to elicit a deeper critical understanding of how different stakeholders in this particular area of interest speak about and make sense of the reality around them (Taylor, 2004, p.436). Furthermore the various effects of discourse on the subjects within the field were explored with a particular emphasis on dominant discourses. The ideas of Foucault served as the base of the critical approach since, in a similar way to the proposed study, a Foucauldian approach is accurately described by Graham (2005), as being primarily led by the exploration of power and knowledge relationships enacted through discourse (p.3). Having already referred to the work of Foucault and his understanding of concepts such as power and truth, it seemed natural to follow the same model in the gathering, analysis and interpretation of data. Hence following a Foucauldian approach in all phases of the study, may have facilitated the maintenance of an integrative and continuous approach throughout.

In a faithful manner to the philosopher himself, Arribas-Ayllon and Walkerdine (2008) discussed how in the Foucauldian approach to discourse analysis, it is customary to contend that there are no hard rules but only guidelines (p.91). However, they proposed three dimensions that may serve as the basis of a Foucauldian Discourse Analysis:

Firstly, the analysis of discourse entails *historical* enquiry...secondly, analysis attends to mechanisms of *power* and offers a description of their functioning. And lastly, analysis is directed to *subjectification* – the material signifying practices in which subjects are made up (Arribas-Ayllon and Walkerdine, 2008, p.91).

The method of research in this study has been broadly based upon the broad guidelines discussed by the mentioned authors but custom modified according to the needs arising from the study – this will be discussed in further detail in section 3.3.3.

### 3.3 The research design

The study consisted of two phases, as depicted in Figure 2. Each of the phases was aimed at collecting data from different sources in order to enable the gathering of data that is holistic and comprehensive in nature.

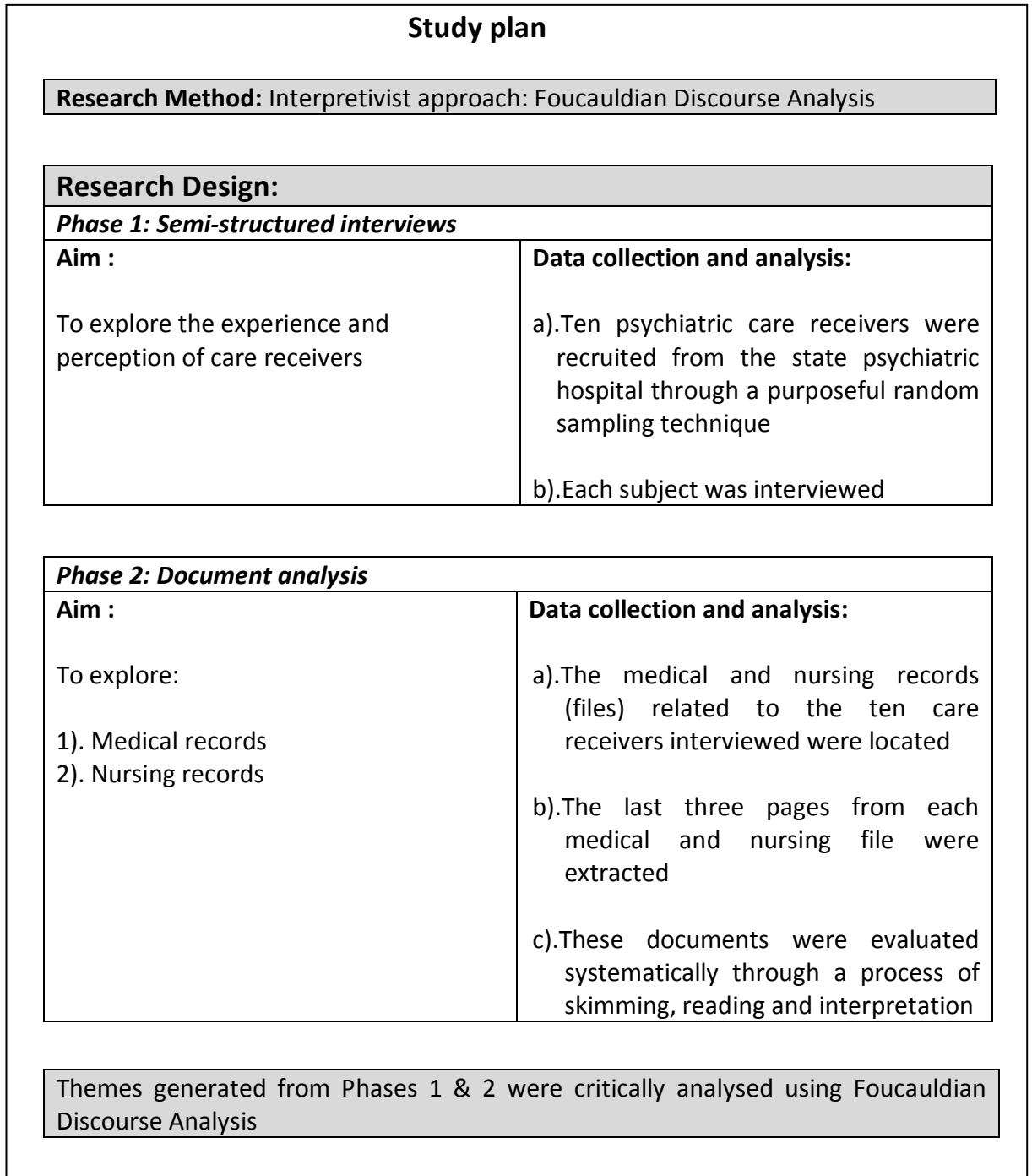


Figure 2: The research plan

The aim of the first phase of the study was to interview care receivers in order to explore their perception regarding the area of the knowledge-power balance in the psychiatric therapeutic alliance. The second phase consisted of a data collection process by means of exploring and analysing the medical and nursing records of the ten participants interviewed in Phase 1. In this manner, Phase 1 of the study involved the recruitment of human subjects in order to collect verbal data, as opposed to, but also complementing the collection of written data from existing documents, which was carried out in Phase 2. Essentially, the involvement of two phases was targeted at allowing data and methodological triangulation, by the use of a different data source and method during each phase.

As encompassed by Thurmond (2001), triangulation offers multiple benefits, the outstanding ones being: the contribution to the researcher's confidence level in the collected data, the identification of discrepancies as well as enhanced understanding of the area under investigation (p.253). In view of this, the use of a multiple-strategy method in this study was intended to contribute to the aspects of utility and validity. It has to be noted that triangulation is time-consuming and requires more resources. This challenge was addressed by planning and organising the research timeline in the best way possible to the knowledge of the researcher and as guided by the supervisor. Further challenges associated with this technique include: investigator bias resulting in data disharmony and conflicting data collecting methods (Thurmond 2001, p.256). During each step of the research process, the researcher sought advice from knowledgeable individuals in the field so as to counter-check processes such as sampling and analysis in an attempt to lower the incidence of investigator bias or oversight. Each of the two phases of the study shall be described in more detail in the following section.

### **3.3.1 Phase 1 – Semi-structured interviews**

#### **Selection of participants**

A vast amount of literature related to the area of interest in this study involves the perceptions of professionals in the field of psychiatry. These works are of utmost importance in answering the set research questions and have been integrated with the analysis and discussion of the findings. However, current trends fuelled by evidence-based reasoning, depict the care receiver as being an expert by experience – placing him/her in the central, active position of the treatment programme (McLaughlin, 2009, p.1111). Hence in this study, I wished to give care receivers a direct voice and to have the opportunity to enquire about and endeavour to partly understand the knowledge-power construct from a care receiver's point of view.

Additionally, it is widely agreed that the philosophy at the heart of the therapeutic alliance is to promote and enhance the therapeutic effect. On further thought, it can be realised that the measurement of the perceived effectiveness of the alliance is subjective – a case in point is a scenario where the care receiver is compliant, submissive and passive – characteristics which may be regarded by the professional as beneficial and even ideal in maintaining a smooth relationship. However, these characteristics may be masking a helpless and frustrated patient, which may be detrimental to the recovery process. This emphasises the importance of exploring the care receiver's view in addition to the care provider's perception. For this reason, it was eventually concluded that Phase 1 of the study was to be entirely dedicated to listening to care receivers.

#### **Sample size determination**

As postulated by Creswell (2003), in interpretivist research, sample sizes need to be small in order to allow the researcher to collect comprehensive detail about the subject and the scenario where the study is being carried out (p.222). This implies that representativeness and generalisability may be sacrificed in the process - however, these two factors do not usually feature in the aims of research that has a qualitative nature. The determination of the sample size is an important decision that has to be made by the researcher and it is one which is not characterised by a

standard rule in interpretivist research. In this study, it has been reasoned that having just one or two individuals would not have sufficed in answering the research questions comprehensively. Contrastingly, involving a large number of participants may have resulted in an overwhelming amount of data which in turn, may have deterred the researcher from fully immersing in the deep understanding and analysis of the data collected. The final number of ten participants was selected on the virtue that it is a compromise based on the argument that has just been put forward.

### **Sampling technique**

Selecting a sample in a random fashion is a well-defined and rigorous approach, commonly used in positivist studies (Blaxter, Huges & Tight, 2006, p.163). In order to use a random method of sampling, ideally, there is some knowledge about the whole population in relation to the area being studied, as well as the assumption of a normal distribution of similar trends within the said population. This tends to defy the aim of the interpretivist approach used in this study, which revolved around the desire to focus on a specific area that has not yet been thoroughly explored. Furthermore, the area holds significance and interest for a selective and limited group of individuals and thus it was probably more productive to gather data from these sources rather than randomly selecting potential participants. Selection by virtue of convenience was avoided due to widespread criticism revolving around the lack of rigour and intellectual credibility, albeit being a tempting sampling technique with minimal costs in terms of time and effort (Offredy & Vickers, 2010, p.139). It was consequently decided to use a purposeful random sampling technique. Teddlie and Yu (2007, p.90) described how this involves two steps: the first step consists of selecting a specific subset of individuals, as happens in purposeful sampling. Subsequently, a random sample is selected from that sub-group. The strength of this method is that it combines some of the advantages of random sampling and purposeful sampling. In this study, the sample was selected by:

- Selecting those participants who were currently making use of inpatient state psychiatric services and who fell under the responsibility of those consultant psychiatrists who gave their permission for the care receiver interviews and for accessing medical and nursing records.

- Involving knowledgeable professionals (multidisciplinary team members) to determine which of the individuals selected satisfied the inclusion/exclusion criteria.
- Selecting a random subset of eleven participants from the list that resulted. One of the participants was selected for potential participation in a pilot study whilst the remaining ten participated in the actual data collection process.

The following exclusion criteria were applied during recruitment:

- (i). Children under 18 years of age
- (ii). Individuals who have been legally incapacitated
- (iii). Individuals with temporary, borderline, fluctuating or unclear incapacity to consent and participate due to the nature of psychiatric symptoms
- (iv). Individuals whose current or partially predictable (arising from familiarity with the potential participant and his/her history) psychological state may have:
  - Impaired the individual from providing informed consent and participate meaningfully in the study (for the purpose of criterion (iii)) or;
  - Be affected negatively as a result of participating in the study

The participants who were selected for potential inclusion consisted of five males and six females within acute, chronic and rehabilitation wards. One of the female participants participated in the pilot study which rendered the actual study sample to be made up of a balance of males and females.

Once the potential participants were identified, the nurse in charge of the unit where each participant was situated was contacted. Information about the study procedure was provided and the nurse was then asked to approach the potential participants to ask them whether they wished to participate in the study. A recruitment form was provided with instructions on the process that the nurse needed to undertake as well as the ethical considerations that had to be followed by the nurse during and after this process. Subsequently, the nurses in charge of the respective unit approached the

potential participant and explained about the study process as well as presenting the individual with the information sheet. If the participant approved, I was contacted and could then proceed to make contact with the individual. During this meeting with the potential participant, I described the study procedure, clarified any difficulties and then presented the consent form. The interview could then be carried out.

### **Data collection method**

In order to determine the data collection method, various research tools and techniques were evaluated and rated on their potential for providing the richest data. During this phase, data collection could have been carried out through a myriad of possibilities. A semi-structured interview technique was conclusively chosen to collect data from the participants (Please refer to Figure 4 on p.124 for the interview guide). If one were to take a critical stance, it can be argued that this data collection method is mainly limited by its time consumption since the varied and free nature of the questions and answers necessitates lengthy interviews followed by analysis (Gillam, 2000, p.9). In any research study, the researcher is inevitably faced with the constant struggle between effectiveness and efficiency. In view of Phase 1 of this research study, it was deliberately decided to tip the scales towards the 'effectiveness' side. As elaborated in previous sections, one cannot ignore the fact that the specific area of the study has not been thoroughly researched. This implies that this subject needs detailed exploration as well as possible clarification and explanation to the participants during the data collection period. Hence, a semi-structured interviewing technique may have had a higher probability of being effective in comparison to other methods of data collection (Barroso, 2009, p.119). This originates from the knowledge that a semi-structured interview may transcend other techniques in that it allows the fieldworker to use an interviewing structure which allows a degree of freedom. This gives the researcher the license to explore emerging data in a fashion that depends solely on the direction that each interview takes. Essentially, initial responses can be probed and the respondents are enabled to talk freely, in the strive to gain further detail and clear answers (Creswell, 2003, p.190). The semi-structured interview schedule was based on the research questions



leading the study and guided by literature on the topic. Appendix 1 shows the link between each interview question and the main/sub research questions posed at the beginning of the study. Prior to the actual study, a pilot study was carried out in order to test the interview guide as well as to practice my interviewing skills. Following the pilot interview, changes to the guide were made according to feedback from the care receiver involved and based on self-reflection.

### **3.3.2 Phase 2 – Document analysis of medical and nursing records**

Following the interviews with the participants, the study proceeded to the second phase which involved the review and analysis of professional records pertaining to the participants who were interviewed in the first phase. The decision to use records as a data source was based on the fact that records are an important means of professional communication and contain feedback that may delineate care (Berman & Snyder, 2007, p.252). More importantly, records contain information about the nature of the therapeutic alliance and the care process. The documents chosen for inclusion were medical and nursing records. Medical records consist of a specific handwritten file that contains reports about a particular care receiver as written by the doctor only whereas nursing records are compiled by nurses and can be found in a separate handwritten file. The rationale for choosing records written by doctors and nurses was based on the knowledge that during a care receiver's stay in the psychiatric hospital, s/he inevitably has contact with these two types of professionals but not necessarily with other professionals such as social workers and occupational therapists. Thus it was reasoned that each care receiver who participated in the study had to have a medical and nursing file which could then be used as a data source for the second phase of the study.

During this phase, I wished to obtain data entries that were as close as possible to the interviews that I had had with the care receiver. This was deemed as desirable in order to obtain Phase 1 and Phase 2 data within the same cross section in time. In this manner, the two data sources could be compared and cross-related to each other. Thus, the last three pages of entries in each medical and nursing file dated before each care receiver's interview were selected.

### 3.3.3 Data analysis

The interviews were transcribed by the researcher using a denaturalised verbatim technique. Oliver, Serovich and Mason (2006) described how this technique is particularly used in critical discourse analysis as well as in grounded theory and ethnography. On explaining how to use this transcription method, the authors emphasised that “accuracy concerns the substance of the interview” (p.1276). This is brought about by a researcher who focuses on the meanings and perceptions that are shared during the interview rather than on emphasising accents, minor non-verbal details or involuntary verbal sounds.

At times, during the interview, the participants mentioned others by their name – in these cases, the names have been changed in order to maintain anonymity. Eight of the participants preferred to have the interview in Maltese whilst two of them opted to use the English Language. The Maltese interviews were transcribed in the Maltese language and then translated to English. Back translation was then carried out in order to attempt to ensure that the meaning conveyed by the participants was retained following the translation process. The pages extracted from the medical and nursing records were inputted into a word processor by the researcher. The records had been originally written in English and so no translation was required.

At this stage, the transcripts and the typed records were ready to undergo analysis. When it comes to performing Foucauldian Discourse Analysis, a number of guiding frameworks have been proposed in an attempt to lend structure to a type of analysis that can be quite complex to address (Arribas-Ayllon & Walkerdine, 2008, p.95). On a parallel note, general guidance on the subject offers the luxury of a freehand approach that allows the researcher to be creative and to borrow Foucault’s methods without adhering religiously to any existing framework. Despite the fact that this latter advice held considerable attraction, the fact that I am a novice researcher led me to consider the structured models that have been proposed by experienced others. The principle authors in the field of Foucauldian Discourse Analysis frameworks are Willig (2008), Parker (1994; 1992), Burman (1996; 1992), Kendall & Wickham (1999), Hall (2001) and Arribas-Ayllon & Walkerdine (2008). On reviewing each of their methods, the ones by Willig (2008), Parker (1994; 1992), Burman (1996; 1992)

and Arribas-Ayllon & Walkerdine (2008) emerged as being the most appropriate in terms of their faithfulness to the main contentions of the Foucauldian philosophy as well as their simplicity and applicability to the current study. Furthermore, some of the steps of the thematic analysis framework proposed by Braun and Clarke (2006) were seen as potentially useful in the initial stages of analysis that constituted the organisation of the data collected in the study. The dilemma faced was that whilst there was some overlap between the steps described in the different frameworks, each of these methods had some useful individual differences – this rendered it difficult to decide upon a single method for use. In an attempt to address this issue, the steps of these five frameworks were merged, synthesised and adapted for use into a new model that is, by nature, based on an eclectic approach. This seemed like a good compromise and one that led to the new framework that is depicted in the next page (Figure 3).

Figure 3: Steps in carrying out Foucauldian Discourse Analysis

Step	Explanation
1). Data acquaintance	A process of becoming familiar with the data by multiple reviews and ongoing reflection about connotations and meanings.
2). Primary analysis: General thematic coding	Codes are generated by a process of open coding which involves the coding of data chunks based on the meaning that emerges from the data. Codes are then collapsed and listed. They are then analysed for possible further reduction or addition of new codes. At this stage, codes are of a generic nature and not exclusively related to knowledge-power.
3). Secondary analysis: Main discursive themes related to knowledge-power	A process of scrutinising the data and the codes that emerged from the primary analysis. This is done in order to identify themes based on the knowledge-power interface in relation to the discursive object, which is the therapeutic alliance.
4). Discursive constructions	All instances of reference to the discursive object including both implicit and explicit ones. What is the discursive object according to the text?
5). Dominant Discourses	This entails reflection on the discursive constructions and their location within wider discourse-types.
6). Subject positions	These are positions offered by the dominant discourses on the discursive object.
7). Subjectivity and Technologies	Consequences of taking up various subject positions for the participants' subjective experience. This includes, feelings, thoughts and experiences as well as potential gains and losses within various subject positions. Technologies are forms of rationality for the government of self ( <i>technologies of self</i> ) or others ( <i>technologies of power</i> ) (Foucault, 1982, p.18).
8). Effects of discourses on practice	The possibilities and rules for action mapped by the dominant discourses.

The framework that has just been described was not intended to serve as a stepwise structure that had to be rigidly adhered to during data analysis. This would have risked the reduction of this analysis to a simple set of steps that would have probably not done any justice to the discursive object. Conversely, these steps were intended to act as a rough guidance to the process in an attempt to enhance comprehension and flow of the arguments. It is hoped that this also facilitated the undertaking of Foucauldian archaeological and genealogical analyses of the therapeutic alliance in contemporary mental health services. The framework described was used to guide both the analysis of the data as well as the discussion presented in Chapter 4 - in this subsequent chapter, further detail and data examples of the steps carried out in accordance with this framework will be provided.

## **3.4 Ethical considerations**

### **3.4.1 Ethical approval**

Prior to the data collection process, a research proposal was submitted for review and approval by the ethics committees at the University of Malta and University of Sheffield.

### **3.4.2 Informed consent**

In order to limit the possibility of influencing or pressuring potential participants, the initial invitation for participation in the study was not made by the researcher but by the nurse in charge of each respective unit. The nurse was provided with information about the study procedure, instructions on the process that s/he needed to undertake as well as the ethical considerations that had to be followed by the nurse during and after this process. The nurse was then requested to approach the potential participant and explain about the study process as well as presenting the individual with the information sheet. It was only if and when the subject approved, that the researcher was informed. Following this, the researcher proceeded to make contact with the individual. During this meeting, the researcher once again explained about the study procedure, clarified any difficulties and then presented the consent form. The consent form included permission requests for an interview and for accessing

medical and nursing records pertaining to the care receiver. Participants were asked for their permission to record the interview and to take field notes. With regards to accessing the medical /nursing records, the following measures were taken:

- The patient's information letter and consent request his/ her permission for access to the records. This also included the rationale behind the need to use this information.
- Only information that was directly relevant to the study was included.
- The medical records and nursing reports were not removed from the hospital grounds and the soft copies (typed by the researcher) were not shared with anyone else.

Permission and consent forms were also obtained from the responsible institutional bodies such as the general hospital management, the national and hospital data protection officers, the medical and nursing management as well as the consultant psychiatrists in the hospital.

### **3.4.3 Anonymity and confidentiality**

During the interviewing process, complete anonymity could not be achieved since I carried out the interviews myself. However, the use of coding instead of actual names in the study report limited the chance of the participants' identity being revealed. The information disclosed by the participants during the interview was kept confidential. Moreover, data that contained direct clues to revealing the identification of the participants, was omitted. In this way, the individual's privacy and dignity were sought to be ensured at all times. Hard data, involving recordings and transcriptions, was stored securely in a locked environment whilst soft data was password protected. All data was destroyed on completion of the study.

### **3.4.4 Protection from discomfort and harm**

To the best of the researcher's knowledge, the self-designed interview questions were formed in such a way that should not evoke harmful emotions and were discussed with the supervisor. However, if during the interview, the researcher had

been aware that such harmful reactions were nonetheless being evoked, the interview would have been terminated immediately and the participant supported as necessary. After the interview, each participant was once again provided with the researcher's contact details and informed to make contact if s/he would like to discuss any issue.

A clinical psychologist was also identified for the individual to contact, in the eventuality that psychological support would have been needed.

### 3.5 Chapter conclusion

During the design phase of the study, the priority was to select a method that enhances the trustworthiness and the quality of the research that was going to be undertaken. Shenton (2004) discussed general factors that may be considered by a qualitative researcher in order to enhance trustworthiness. Additionally, Parker (2005) and Yardley (2000) outlined other criteria that characterise good research – the criteria discussed by these two authors apply more specifically to Foucauldian Discourse Analysis. The following table depicts factors and measures taken during the current study in order to enhance the quality, in relation to the guidelines provided by Shenton (2004), Parker (2005) and Yardley (2000).

Table 1: Measures taken to enhance quality

Quality criterion	Suggested provisions by Shenton (2004, p.73), Parker (2005, p.142) & Yardley (2000, p.219)	Provisions made during the current study
<b>Credibility</b>	<p>Adoption of appropriate, well recognised research methods</p> <p>Development of early familiarity with culture of participating organisations</p> <p>Triangulation via use of different methods, different types of informants and different sites</p> <p>Tactics to help ensure honesty in informants</p>	<p>Foucauldian Discourse Analysis</p> <p>Researcher's professional background</p> <p>Two study phases with different participant-types and data collection methods</p> <p>Emphasised right to refuse participation/ withdraw from the study</p>

<p><b>Credibility contd.</b></p>	<p>Iterative questioning in data collection dialogues</p> <p>Negative case analysis</p> <p>Debriefing sessions between researcher and superiors + Peer scrutiny of project</p> <p>Use of “reflective commentary”</p> <p>Description of background, qualifications and experience of the researcher</p> <p>Member checks of data collected and interpretations/theories formed</p> <p>Thick description of phenomenon under scrutiny</p> <p>Examination of previous research to frame findings</p>	<p>Reassured about anonymity and the fact that there are no right or wrong answers</p> <p>Questions were rephrased and probing was used in cases where interview data was unclear</p> <p>Codes and themes were analysed and re-analysed in order to detect possible errors in classification</p> <p>Carried out with clinical and academic colleagues</p> <p>A reflective diary was kept throughout the study</p> <p>These have been provided in the introductory section of this thesis</p> <p>The data collected was verified and checked with the participants</p> <p>An attempt was done to address this in Chapter 4</p> <p>An attempt was done to address this in Chapter 2 and Chapter 4</p>
<p><b>Transferability</b></p>	<p>Provision of background data to establish context of study and detailed description of phenomena in question to allow comparisons to be made</p>	<p>An attempt was made to address this in Chapters 1,2 and 4</p>
<p><b>Dependability</b></p>	<p>Employment of “overlapping methods”</p>	<p>The medical and nursing records included in Phase 2 of the study pertained to the care receivers interviewed in Phase 1 in an attempt to overlap data related to the same set of therapeutic alliances</p>



<b>Dependability contd.</b>	In-depth methodological description to allow study to be repeated	An attempt was made to address this in the current chapter and chapter 4
<b>Confirmability &amp; Objectivity</b>	<p>Triangulation to reduce effect of investigator bias</p> <p>Admission of researcher’s beliefs and assumptions</p> <p>Recognition of shortcomings in study’s methods and their potential effects</p> <p>In-depth methodological description to allow integrity of research results to be scrutinised</p> <p>Use of diagrams to demonstrate “audit trail”</p>	<p>Two different data sources and data collection methods were employed</p> <p>An attempt was made to address this in Chapters 1,2 and 4</p> <p>An attempt was made to address this in Chapter 5</p> <p>An attempt was made to address this in the current chapter and Chapter 4</p> <p>An attempt was made to address this in Chapter 4</p>
<b>Transparency &amp; Coherence</b>	<p>Clarity in the presentation of method and data</p> <p>There is a fit between the theory and method used</p> <p>Use of reflexivity</p>	<p>A descriptive account and diagrams were used to depict the research method and design in Chapter 3 and the findings in Chapter 4</p> <p>Foucauldian Discourse Analysis was used as it complements the theories of Foucault which underpin this thesis</p> <p>A reflective diary was kept during the process. Instances of reflection can be noted in the written account especially in Chapter 4</p>
<b>Sensitivity to context</b>	<p>The method chosen is appropriate to the sociocultural setting</p> <p>Ethical issues are considered in detail</p>	<p>Foucault’s contentions about knowledge-power may offer insight about the area and the situation in the local setting</p> <p>Ethical issues have been described in detail in this chapter</p>

<b>Accessibility</b>	Presentation of the method and data needs to be as simple as possible to allow access to those inside and outside the discipline	Ornate descriptions and complex layouts have been avoided as much as possible. The use of technical jargon has been limited and explanations have been provided when complex terms were used
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Figure 4: Guide for semi-structured interviews with care receivers

**Semi-structured interview guide**

Please describe the events that led to your first contact with mental health services.  
Did you decide that you needed psychiatric help or was this decided by someone else?

If this was decided by someone else: How did you feel? What did you think? How were you informed – what did they tell you?

Did you choose the type of mental health service? e.g. admission to psychiatric hospital, psychiatric outpatients appointment or community services

On which basis did you make this choice?

If someone else made the choice for you, did you agree with this decision?

What do you know about your symptoms?

Where did you get this knowledge from?

What kind of information regarding your symptoms have you been given by the professionals that you have been involved with in the hospital?

Do you feel as if you know enough about your symptoms?

If not, what kind of knowledge do you think you need?

What is the plan for your care and how was it formed?

Were you involved in the formation of this plan?

If not, did you wish to be involved? Why?

What treatment are you receiving? (Here referring to psychological, complementary & alternative or pharmacological interventions)

Have you been provided with available treatment options?

How is the final choice of treatment done?

What information were you given about the treatment from the person who prescribed it?

Are you satisfied with your treatment?

If you were ever unsatisfied, what would you do? Why would you do this?

How easy is it for you to understand the meaning of the language of your care providers?

Describe your perception of your role within the multidisciplinary team.

What influences the way that you perceive your role in this team?

What are the professions of the psychiatric care-providers that you have a working relationship with? (emphasis on no need to mention actual name)

How do you feel when you are with \_\_\_\_\_ ? (to fill in blank with each professional type consecutively e.g. *with your psychologist*)

Describe what happens in a typical session with \_\_\_\_\_ (to fill in blank with each professional type consecutively).

What happens/ think would happen, if /when you give feedback and suggestions to \_\_\_\_\_ (to fill in blank with each professional consecutively) regarding your treatment and care plan?

Do you feel as if you have less, equal or more power/say in your relationship with \_\_\_\_\_ ? (to fill in blank with each professional consecutively)

Are you satisfied with the balance of power in your relationship with \_\_\_\_\_ ? (to fill in blank with each professional consecutively) Why?

If not, what would you change?

What do you think are the factors that make this power balance as it is?

In general, do you feel as if your suggestions and feedback are considered and used to change your care plan if necessary?

You are the expert of your own care. What do you think about this? (Or: Do you see yourself as having knowledge about your response to the symptoms and then using this knowledge to work with your care providers?)

Do you think that your care providers can learn from you?

If yes, what type of knowledge do they need to obtain from you?

Do you think that your care providers wish to learn from you? How do you know this?

How comfortable would you feel in sharing your knowledge with \_\_\_\_\_ (to fill in blank with each professional type consecutively?)

What kind of knowledge do you think a care receiver needs in order to be able to manage power effectively with a care provider in a professional relationship?

What kind of support do you think a care receiver needs in order to be able to manage power effectively with a care provider in a professional relationship?

What kind of knowledge do you think a care provider needs in order to be able to manage power effectively with a care receiver in a professional relationship?

What kind of support do you think a care provider needs in order to be able to manage power effectively with a care receiver in a professional relationship?

## *Chapter 4*

# **ANALYTICAL DISCUSSION OF FINDINGS AND IMPLICATIONS**

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### **4.1 Chapter introduction**

In this chapter, the analysis and discussion of the findings and their implications shall be presented. Data excerpts shall accompany the discussion in an attempt to remain as faithful as possible to the original sources. Excerpts are coded so as to facilitate their location in the transcript/record from which they emerged – the letters in the code refer to the source type: CR [Care Receiver interview], MR [Medical Record] or NR [Nursing Record] followed by a number which indicates the specific interview transcript or record. This is then followed with the exact location within the specific source. As an example, [CR1:56] translates to Care Receiver 1, quote 56 whereas [MR3:E4] refers to Medical Record 3, entry 4. In some of the excerpts, there are words that have been italicised and bracketed - these indicate explanations that I have provided in order to clarify that particular excerpt. Each of the interview transcripts and medical and nursing records are found on the DVD that accompanies this thesis.

In order to ascertain that the research questions are being addressed, the structure of this chapter has been set according to the three questions leading the study. In this regard, the chapter has been divided into three parts:

### **4.2 Analysis and discussion of the interviews with care receiver participants**

### **4.3 Analysis and discussion of the medical and nursing records**

### **4.4 Developing the effectiveness of the therapeutic alliance**

Sections 4.2 and 4.3 individually address the main question and first sub question, namely:

- What is the nature of the combination of knowledge and power in therapeutic alliances in a mental health in-patient setting in Malta?
- What role do the dominant discourses play in the positions occupied by care providers and care receivers in therapeutic alliances in a mental health in-patient setting in Malta?

Section 4.4 addresses the second sub question, namely:

- What type of knowledge is required by care providers and care receivers for power to be managed in a manner that may enhance therapeutic effects in this setting?

As discussed previously, there were two data sources feeding this study - the first source was mental health service users and the other was medical and nursing records written by professionals pertaining to the same service users who were interviewed. Although initially each of these two data sources was treated individually and separately for each service user, they were then also reviewed as a whole unit specific to that service user. This enabled the formation of a more holistic picture and better identification of patterns within each therapeutic alliance. Thus, although Section 4.2 (Care receivers' interviews) and Section 4.3 (Medical and Nursing records) specifically address each of the data sources of the study, cross-references will also be made between the two parts in instances when it is felt that there may be a possible link between the two data types.

It is hoped that in this manner, the constructs of the balance of knowledge and power in the alliance between the care provider and care receiver in mental health services will be adequately analysed and critiqued as guided by the Foucauldian Discourse Analysis framework which was discussed in Chapter 3 and presented again in the next page (Figure 5).

Figure 5: Steps in carrying out Foucauldian Discourse Analysis

Step	Explanation
1). Data acquaintance	A process of becoming familiar with the data by multiple reviews and ongoing reflection about connotations and meanings.
2). Primary analysis: General thematic coding	Codes are generated by a process of open coding which involves the coding of data chunks based on the meaning that emerges from the data. Codes are then collapsed and listed. They are then analysed for possible further reduction or addition of new codes. At this stage, codes are of a generic nature and not necessarily related to knowledge-power.
3). Secondary analysis: Main discursive themes related to knowledge-power	A process of scrutinising the data and the codes that emerged from the primary analysis. This is done in order to identify themes based on the knowledge-power interface in relation to the discursive object, which is the therapeutic alliance.
4). Discursive constructions	All instances of reference to the discursive object including both implicit and explicit ones. What is the discursive object according to the text?
5). Dominant Discourses	This entails reflection on the discursive constructions and their location within wider discourse-types.
6). Subject positions	These are positions offered by the dominant discourses on the discursive object.
7). Subjectivity and Technologies	Consequences of taking up various subject positions for the participants' subjective experience. This includes, feelings, thoughts and experiences as well as potential gains and losses within various subject positions. Technologies are forms of rationality for the government of self ( <i>technologies of self</i> ) or others ( <i>technologies of power</i> ) (Foucault, 1982, p.18).
8). Effects of discourses on practice	The possibilities and rules for action mapped by the dominant discourses.

## **4.2 Analysis and discussion of the interviews with care receivers**

### **4.2.1 Introduction**

This section of the chapter is primarily concerned with the analysis and critical discussion of the interviews with the care receivers who took part in this study.

My experience of participating in the interviews was an unforgettable one. The raw emotions and perceptions that my participants shared with me were extremely touching to the point of being overwhelming and the words that they used were characterised by tremendous insight and power. Some of the experiences that they described instilled in me a mixture of long lasting sadness and deep rage, yet, at times, I found myself cheering along the more positive narratives that I was presented with. Initially I had approached the data collection process with confidence based on the fact that I was familiar with the setting and the area of research. At that point, little did I know that I would soon be finding myself in a whirlpool of emotions and in a challenge to distinguish between my role as a researcher and a clinician. On several occasions, especially during the interviews, I was clearly aware of a strong temptation to switch into the clinician mode. On reflection, I now realise that probably, this had been due to my automatic reaction to the realisation that some of the participants were using the interview as a therapeutic opportunity. I cannot help but wonder whether this was a direct result of the lack of attention and therapeutic opportunities within the psychiatric setting which was highlighted by some of the participants during the interviews. At the risk of inflating my importance, it seems to me as if the interviews may have given some of the participants a much needed and awaited opportunity to talk and to shine but most of all to be the main focus of another person's attention. During most of the interviews, I felt as if I had opened the gates of a dam and the water burst out with such a powerful force that it tended to topple me over. Yet, my initial shock led to a lot of reflection and to my recommendations for a new way of practice as identified by the care receivers.



Whilst analysing and discussing the findings, I was faced with yet another challenge due to my urgent need to present my participants' voice in the most faithful and comprehensive manner possible. For me, the process of writing this chapter was cathartic as it served as a channel to convey my feelings. At the same time, I am painfully aware that as powerful as writing can be, in this case, I feel that it still falls short in representing the actual interview experience. In an attempt to enhance representativeness, I have included several excerpts since I feel that these convey the most powerful message of all. From the very beginning, I became increasingly aware that I needed to contain my emotions and structure my presentation. Thus, I decided to develop and use the Foucauldian Discourse Analysis framework that has been described earlier (Refer to Figure 5 – p.128). Perhaps the use of such a framework may appear as robotic or rigid. Yet, to me, it proved to be a useful guide that helped me to stay on track especially when my personal position tempted me to stray.

The first step in the framework involved *Data Acquaintance*. During this process, the main aim was to attain a general feel of the data, particularly that related to the nature of the interview pertaining to each service user who participated in the study. At this point, certain patterns or characteristics began to emerge. In fact, this led to one striking finding which indicates that while some service users have the same type of alliance with all health care professionals, others have different types of alliances with different workers.

Following this immersion in the data, the next step involved primary analysis by means of thematic coding, as facilitated by the qualitative analysis software *Atlas.ti*. This process involved the assignment of words or phrases to data excerpts in order to sum up or capture the understood meaning of the participants' words. During this process of primary analysis, some of the codes assigned were not necessarily specific to knowledge-power issues within the data. This is because at this stage, the objectives were to organise the raw data, clarify the findings, facilitate the initial identification of patterns and allow the preparation of data for secondary analysis.

This led to the third step in the Foucauldian Discourse Analysis process which entailed secondary analysis with identification of the main themes as based on the knowledge-power nexus. On carrying out this process, it became evident to me that

from a Foucauldian perspective, there seem to be four main distinctive themes related to the therapeutic alliance. Each of these themes is characterised by a discursive nature that may be quite clear - in other words, a distinguished way in which care receivers talk about the knowledge-power balance in the therapeutic alliance and behave in its context. In fact, it is being postulated that each of these discursive natures mould the alliance. Hence, these four identified themes serve not only as a classification of the different discourses encountered during the interviews but also as a knowledge-power classification of the types of therapeutic alliances.

In this chapter, the discussion related to Section 4.2 has been structured and presented according to each of these four themes, as the main headings in the discussion. The critical description pertaining to each item has been guided by steps 4-8 of the eclectic Foucauldian Discourse Analysis framework that has been described earlier. In this manner, each discursive theme has been first presented and described, followed by the constructions of the therapeutic alliance within this theme. This leads to the identification of the dominant discourses and their related subject positions as well as potential consequences for different parties within the alliance and for practice.

Before exploring these four discursive themes in detail, an overview and presentation of the analysis (based on steps 1-3 of the Foucauldian Discourse Analysis framework) shall be presented as follows in order to depict the main results and lead the way to the discussion that entails (based on steps 4-8 of the same framework).

## **4.2.2 Analysis of the interviews with care receivers**

### **Introduction**

The first step undertaken during the analysis of the interview transcripts was the reading and re-reading of the transcripts as well as listening to the audio recordings. This process of data immersion was necessary so that I could become familiar with the data and reflect upon the specific meaning of particular words and phrases as well as the overarching nature of each interview.

### **Primary analysis: general thematic coding**

As already indicated, this process involved the assignment of codes to data. This was carried out so as to attempt to provide order to the raw data in order to enhance clarity. Furthermore, it also facilitated the initial identification of patterns and allowed the preparation of data for the next step - secondary analysis. Inductive coding was undertaken and the resulting codes were reviewed and amended repeatedly in order to allow reduction and refinement of the code list that was compiled. A worked example and a list of primary codes that resulted from the process of thematic coding is found in Appendix 3.

### **Secondary analysis: main discursive themes related to knowledge-power**

Following the primary analysis process, the interview transcripts and the assigned codes were reviewed again. At this stage, the aim was to further categorise and reduce the coded data underneath main themes related to knowledge and power.

This process led to the identification of four main discursive themes in relation to the knowledge-power interface within the therapeutic alliances explored in this study. As already alluded to in the introduction, each of these themes describes a particular manner of how the care receivers spoke about and were understood to perceive each of their different alliances with various professionals. This implies that each of the four themes describes a particular and specific type of alliance, as depicted in Table 2. It could be noted that during some instances, care receivers identified and discussed a particular individual care provider e.g. the psychiatrist. On other

occasions, they referred to a specific professional group e.g. the nurses, and proceeded to describe the alliance with this group as if it were an alliance with one individual rather than many.

During the interviews, the participants provided information about a total of 27 therapeutic alliances that they have with different professionals. Each of these alliances has been categorised underneath one of the four identified themes as follows:

Table 2: Frequency of the four alliance types (*Note: The text in brackets indicates the professional/s with whom the care receiver is in a therapeutic alliance*)

Participant number	Alliance type			
	Satisfaction-Acceptance	Dissatisfaction-Compliance	Resentment-Opposition	Collaboration
1		1 (Nurses)	1 (Psychiatrist)	
2	1 (Psychiatrist)	1(Nurses)		
3				3 (Nurses, social worker, psychiatrist)
4	1 (Nurses)		1 (Psychiatrist)	
5	2 (Occupational Therapist [OT], social worker)	2 (Psychiatrist, nurses)		
6	1 (Psychiatrist)		1 (Nurses)	
7	1 (Nurses)		1 (Psychologist)	2 (Psychiatrist, OT)
8				3 (Nurses, occupational therapist, psychiatrist,)
9	1 (Nurses)		1 (Psychiatrist)	1 (OT)
10	1 (Psychiatrist)	1 (Nurses)		
<b>Totals:</b>	<b>8</b>	<b>5</b>	<b>5</b>	<b>9</b>

Table 3 summarises the whole analysis process. It presents the codes that emerged from the primary analysis and how they were categorised into themes during secondary analysis. These themes were then further explored to identify the discursive constructions of the therapeutic alliances and the dominant discourses.

Table 3: The analysis process (care receivers' interview transcripts)

Primary analysis: codes	Secondary analysis: main discursive themes	Discursive constructions (of the therapeutic alliance)	Dominant discourses	Subject positions
Perceived power imbalance in alliance Acceptance Satisfaction with power-balance type in alliance Active involvement in care Reference to Traditional Medical Hierarchy Determination Expression of trust in professionals Perceived subjection to expected submission Ready to address disagreement/ give feedback	<b>Satisfaction-Acceptance</b>  Key features:  <i>Knowledge-Power imbalance</i> <i>Acceptance of imbalance</i> <i>Overall satisfaction</i> <i>Some degree of care receiver independence</i>	Life-line Clinical tool Loving bond	Compliance Discourse Romantic Discourse	Affinity for tradition Partial submission Self-induced paternalism Professional love Excitement and purpose
Perceived power imbalance in alliance Compliance Displeasure Hopelessness Fear Perceived subjection to expected submission Disagreement with professionals/care plan Reference to Traditional Medical Hierarchy	<b>Dissatisfaction-Compliance</b>  Key features:  <i>Knowledge-Power imbalance</i> <i>Acceptance of imbalance</i> <i>Overall displeasure</i> <i>Moderate-high dependence on care provider</i>	A means of care receiver obedience A medium of fear A catalyst to the employment of sanctions Related to displeasure or discomfort	Discontentment Discourse Compliance Discourse	Affinity for tradition Submission Fear Dissatisfaction Sick role

Perceived power imbalance in alliance Resistance Dissatisfaction with power balance type in alliance Anger Displeasure Discomfort Perceived subjection to patronising/paternalistic attitudes Exclusion Disagreements with professionals and/or care plan Perceived subjection to expected submission Perceived subjection to discrediting attitude	<b>Resentment-Opposition</b>  Key features:  <i>Mostly one-sided</i> <i>Unacceptance of imbalance</i> <i>An angry/irritated care receiver</i>	A struggle A punishment tool A mystery An unwanted burden A non-therapeutic temporary relationship	Discontentment Discourse Anarchist Discourse	A survivor role Rebellion Resistance Oppression Displeasure and anger
Perceived power balance in alliance Satisfaction with power-balance in alliance Assertive behaviour Ready to address disagreement/give feedback Determination Active involvement in care	<b>Collaboration</b>  Key features:  <i>Knowledge-Power balance</i> <i>Both entities on same plane</i> <i>Mutual contribution</i>	A collaborative agreement (partnership) A beneficial and gainful system A system that needs to be managed by the care receiver	Assertiveness Discourse Equality Discourse	Pride Satisfaction Involvement A balanced, two-way position

In the next four pages, Figures 6-9 present a concise view of the four main discursive themes with their respective codes. In every diagram, a description of each of the four themes has been provided and a number of excerpts which describe each of the themes have also been included.

**Figure 6: Theme 1 – The Satisfaction-Acceptance alliance-type**

**Description:**

This theme features an alliance where the care receiver perceives the professional as being the entity in the lead and of creating a power imbalance within the alliance. Most of the participants appear to be satisfied with the alliance and seem to be accepting the power imbalance as an automatic and even welcomed state. These individuals often seek active involvement and are ready to provide feedback in the context of the alliance.

**Excerpts that describe the Satisfaction-Acceptance alliance:**

**Care Receiver 4 – Therapeutic alliance with the Nurses**

With the nurses, I feel good. Sometimes I buy things for them too. There are some nurses who give you psychological therapy themselves because they explain to you, speak to you gently and make sure that you understand. Even during their break time. I would speak up if I did not agree with anything that they said. [CR4: 23]

This morning I was given a punishment for not taking the pills - I was not allowed to go to mass. Mass is my religious belief. [CR4:36]

**Care Receiver 5 – Therapeutic alliances with the Occupational Therapist and Social worker**

I feel quite ok when I am with the social worker. I feel safe. And with her help, I have organised my wardrobe. I wish that the occupational therapist would accompany me home again. I would let the social worker know sometimes if I do not agree with what she says or if I have any feedback. Sometimes I tell her, sometimes I don't. She tells me things for my own benefit. I cannot do without my social worker, she is like a daughter to me. She has other people though, not just me. [CR5:28]

I feel very good when I am with the occupational therapist. I open up when I am with her, tell her how helpless I feel and how can I actually manage to do the bed and the other work when I do not have the will to. If I disagreed with something that she said, or had any feedback to give her, I would do so. [CR5:29]

**Care Receiver 6 – Therapeutic alliance with the Psychiatrist**

I feel calm when I am with the psychiatrist, if I am pain free. First he asks you how you feel. So you have to answer in a way that you tell him everything in those few minutes: "I feel this, this and that." Because when you stop talking, he starts. If I do not agree with something that he says, I let him know. [CR6:25]

I am satisfied that I am at a lower level than the consultant psychiatrist. The most important thing is that he understands my problem and helps me. [CR6:32]

**Care Receiver 7 – Therapeutic alliance with the Nurses**

Regarding the balance of power with the nurses: I feel as if I am less than them. I have less power than they do. That is quite clear. It has to be like that otherwise we would become friends with the nurses and it would all get mixed up. [CR7:30]

## **Figure 7: Theme 2 – The Dissatisfaction-Compliance alliance-type**

### **Description:**

This theme depicts an alliance perceived by the care receiver as being characterised by a leading professional and a power imbalance. Most of the participants appear to accept the power imbalance. However, in contrast to theme 1, they seem to communicate a degree of dissatisfaction with certain features within the alliance. Most of these individuals seem to be reluctant to be actively involved in care and may prefer to depend on the professional.

### **Excerpts that describe the Dissatisfaction-Compliance alliance:**

#### **Care Receiver 10 – Therapeutic alliance with the Nurses**

They are ok but I think that most of them are not really interested..you sort of realise when they speak to you..even the way they speak, the tone of voice. Like I am bothering them and they want me to leave them in peace. That is not nice, it makes me feel uncomfortable. [CR10:33]

With the nurses, I am down there, one of many. It is the system. It is the way it has to be. [CR10:33]

#### **Care Receiver 2 – Therapeutic alliance with the Nurses**

If I do not agree with something that the nurses say, I do not always tell them because I am afraid. I am afraid that they will stop something - stop one of the permissions. It has never happened to me but I have seen it happen to other patients. [CR2:28]

I have less power than the psychiatrist in our relationship. Same applies for my relationship with the nurses. [CR2:30]

#### **Care Receiver 5 – Therapeutic alliances with the Nurses and Psychiatrist**

When I am with the nurses, I feel quite ok. Not with all of them though. Mostly it is "Hello" and "Thank you" with the nurses. Sometimes I open up with them but they say: "You will get better. You have a husband who loves you and respects you. Be brave so that you get out of here." I do not think I would tell the nurses if I disagreed with what they said. [CR5:31]

I am scared when I am with the psychiatrist. I am scared about what he is going to tell me. He tells me what is needed and I try to do what he says. What he says goes because it is for my own benefit. [CR5:27]

Same with the nurses - the nurse always has to be on top and so has the psychiatrist. Because they studied to be like that. I believe that they should be on top and I just trust in them. [CR5:40]

I do not know whether anyone had given me information about the pills. Sometimes the nurses explain to me though - they tell me what each pill is for. But sometimes when I ask, they say: "That's what the doctor has prescribed!" [CR5:22]



## Figure 8: Theme 3 – The Resentment-Opposition alliance-type

### **Description:**

This theme depicts a group of individuals who seem to be displeased due to the perceived power imbalance in their alliances with some of the professionals. Most of these individuals show clear disagreement with the professional involved in the alliance and feel as if their rights are not being respected. Resistance and anger were commonly identified as a result of this alliance-type.

### **Excerpts that describe the Resentment-Opposition alliance:**

#### **Care Receiver 1 – Therapeutic alliance with the Psychiatrist**

I was not involved in the care plan. Actually, he just changed my pills without informing me about it. I wish that I'm involved. Because they think that you do not know how to do anything. They decide everything for you. That's not right. First of all, I wish that he (*the consultant psychiatrist*) had not stopped the Seroxat because I had been doing quite well on it. And perhaps they should accept that I can go home again. [CR1:32]

They throw you into this room, as if you are in prison – seclusion - and you feel even more down than you already are. [CR1:18]

#### **Care Receiver 4 – Therapeutic alliance with the Psychiatrist**

I am not satisfied with the treatment that I am receiving here. I try to speak to the doctor about it but he ignores me. He does not wish to speak to me. Nothing. He does not pay attention. The junior doctors visit but they say that they cannot give me any permissions because they speak to the consultant psychiatrist and he does not wish to give me permissions. He does not even come to see me once weekly. I speak to his doctors. They tell me that they speak to him about me. Now I do not know if they really do. [CR4:15,16]

#### **Care Receiver 6 – Therapeutic alliance with the Nurses**

I am not satisfied with the power balance in my relationship with the nurses. This is because they are not people who interact with care receivers in a gentle manner rather than a savage-like manner. This is my opinion, although I know that some others share the same opinion as I do. You cannot speak – only what they say is right. Mind you there are some nurses who are nice, if you ask them to give you X, they would try to give that to you. I think this is caused by the fact that they become big-headed. [CR6:33]

#### **Care Receiver 7 – Therapeutic alliance with the Psychologist**

The psychologist does not help me. I feel embarrassed when I am with her. Because I know that she doesn't want to deal with me, you know. I feel it strongly. Very very embarrassed, I hope I do not see her again. It is ok if she is on the line but I do not want to be accompanied by her because I feel hurt. [CR7:28]

## Figure 9: Theme 4 – The Collaboration alliance-type

### Description:

This theme presents an alliance where the care providers and care receivers seem to be engaged in a partnership that, to an extent, may be characterised by dialogue and shared decision making. As a result, the care receiver perceives a satisfactory balance of power and there seems to be consideration for ‘expertise by profession’ and ‘expertise by experience’.

### Excerpts that describe the Collaboration alliance:

#### Care Receiver 3 – Therapeutic alliances with the Nurses and Social Worker

In the relationships that I have with the professionals, the power is positive. Whenever I asked for something, it was ok. Like reasonable things - if I ask for four Valium pills instead of one, they obviously cannot meet my demand! But the professionals and I always got along. The power is shared in the relationships. We are equal. [CR3:33]

Like he (*one of the nurses*) said: “You have relapsed AGAIN?” And my answer was: “Don’t you think that it is a good thing that I came here for treatment instead of staying outside in a bad way?” I did not answer rudely or whatever. I do not want to be rude. I wish to be good mannered. [CR3:31]

Listen, I may look ‘soft’ but I stand up for myself - what’s right is right, what’s wrong is wrong. [CR3:26]

When I am with the social worker, I feel very comfortable. In a typical session, she comes here to see me, asks me how I am, what is going on. I tell her about what is going on, what I am feeling, what I wish and don’t wish. If I give suggestions, I get feedback, good, bad - it was never bad. Then I have to accept. Not ‘accept’ because ‘accept’ can imply that I just submit to everything but in the situation of a patient, she is not going to say something that will hurt me. She will lay out the options and feedback and ask me what I think about it. I have time to discuss. I am not presented with a rigid answer. [CR3:30]

#### Care Receiver 7 – Therapeutic alliance with the Psychiatrist and Occupational Therapist

This (*alliance with nurses*) is not the same as the occupational therapists – they (*the occupational therapists*) are more like pals, you know. They say: “When you are ready, just come over and you can speak to me if you like.” [CR7:35]

I feel as if I am on the same level as the psychiatrist too. I do, somehow I do. The way I see it, in a few years my mother will not be here. So I have to get on my feet and deal with my doctor. If I cannot deal with my doctor, how am I ever going to deal with anybody else? [CR7:33]

#### Care Receiver 8 – Therapeutic alliances with the Nurses and Occupational Therapist

I feel very good when I am with the occupational therapist. She tells me what I’m doing wrong, tells me what’s going to happen. She’s always there for me. If I have problems, I speak to her. She’s always there for me. If I disagreed with something that she said, I would go and talk to her. [CR8:24]

I feel ok with the nurses. They talk to me, about my problems. If I am not feeling well, I have to go to talk to them. If I disagreed with something that they said or wanted to give suggestions and feedback, I would do that to the nurses. [CR8:26]

## **Conclusion**

Following the presentation of the analysis, the next section consists of a discussion related to the dominant discourses, subject positions and consequences of the four discursive themes that emerged from the interviews with the care receivers.

### **4.2.3 Discussion of the interviews with care receivers**

#### **Introduction**

Analysis of the data collected from the interviews with the care receivers has culminated in four discursive themes/ alliance types, namely:

- Theme 1: Satisfaction-Acceptance
- Theme 2: Dissatisfaction-Compliance
- Theme 3: Resentment-Opposition
- Theme 4: Collaboration

In this section, these discursive themes shall be discussed in detail in the above order and as guided by steps 3-8 in the Foucauldian Discourse Analysis framework that has been used in this study. This involves a description of each of the discursive themes and an examination of the ways through which the discursive object has been constructed within the theme. Subsequently, the dominant discourses are identified as well as the subject positions that they give rise to. Subjectivities and technologies and the effect of the dominant discourses on practice are discussed throughout the theme, especially in the conclusion. Here I would like to note that for the sake of clarity, in this academic exercise, I have presented and described each of the four discursive themes as separate approaches or types of alliances based on a knowledge-power classification. However, in practice, each of these alliance types may be seen as being found on a continuum with possible overlapping and so they may not be as clearly distinguishable as they are in theory.

## **Theme 1: The Satisfaction-Acceptance alliance-type**

### **Introduction**

Eight of the 27 identified therapeutic alliances in the study were mainly characterised by this alliance-type or theme.

This theme features an alliance where the professional seems to be the entity in the lead, as a result visibly creating an imbalance within the same alliance. Interestingly, all the participants who were identified as being within such an alliance-type, appear to be considerably satisfied with the power imbalance and with the overall nature of the alliance. Concurrently, it can be noted that most of the participants exhibit trust in the professional who they are working with and hence view the interactions and the care that they receive from that particular professional in a positive light. It seems as if in this type of alliance, most of the care receivers are allowing themselves to be guided by the professional and trust that the alliance will reach its therapeutic purpose. Interestingly, most of the participants in this alliance-type seem eager to be active within the alliance as exemplified, for instance, by their readiness to provide feedback to the professional. This is in contrast with the *Dissatisfaction-Compliance* alliance-type where most of the care receivers seem to be quite passive and mostly dependent on their care providers.

### **Discussion**

In this discursive theme, the alliance is constructed in various ways by the care receivers who were interviewed. Primarily, the alliance is constructed by some of the care receivers as a life-line: a source of hope for recovery. In this regard, Care Receiver 5 gave a general description of her alliance with the occupational therapists by describing how:

They (*the occupational therapists*) tell you what you can do too. They help me a lot, they even used to come to my house to help me there. [CR5:20]

This is similar to Care Receiver 6's perception when she stated that:

They help me, the professionals and the consultant psychiatrist, they always try to make things better. They (*the professionals*) are there, and in certain situations you'll be needing them, they are there. [CR6:23]

This group of care receivers sometimes regard the therapeutic alliance as a clinical tool that is managed by the health professionals who are the experts in the recovery process. For instance, Care Receiver 7 emphasised that:

The nurses are very good, very nice. Apart from the odd one here and there. They try to discipline you slightly. And they are right, you know. Nurse X tries to do it. We hate it but at the same time it is good, you know. She tells us to get the heck out of our bed and we're all trying to find our way around. She helps us to get our act together. So she's good, you know. [CR7:25]

Finally, it can be noted that the care receivers construct the alliance as that loving bond between a vulnerable person and his/her helper. In particular, this image was conjured during the interview with Care Receiver 5 who referred to her social worker in the following terms:

She tells me things for my own benefit. I cannot do without my social worker, she is like a daughter to me. [CR5:28]

On reflecting on the various discursive constructions of the therapeutic alliance within this theme, it can be noted that a number of discourses may be playing a major role. The first discourse-type that could be perceived from the very start of the interview with this group of care receivers can be labelled as **compliance discourse**. Primarily, this is a group of care receivers who seem to be satisfied with the alliances that they have with particular professionals and who seem to be quite determined to actively engage in the particular alliance in order to improve their current situation and enhance recovery. However, despite evidence that the participants are 'on track', up-to-date with their care plan and mostly motivated, they seem to be equally adamant that the knowledge and power is in the hands of the professionals within the alliance in focus – it is implied that the professionals are the experts and that this should be an accepted fact. Similarly, the need for the care receiver to follow the care provider's wishes or commands – which is the essence of compliance - may also

be viewed as acceptable and necessary by most of the care receivers in this type of alliance. For instance, Care Receiver 6 stated that:

I am satisfied that I am at a lower level than the consultant psychiatrist. The most important thing is that he understands my problem and helps me. [CR6:32]

It has to be acknowledged that I was surprised by this finding – here I was being presented with these individuals who are seemingly content, active within the alliance and considerably interested in their care plan but yet hold such a conservatist view of the psychiatric system. In this aspect, the care receiver participants may be showing loyalty to the traditional hierarchical system in psychiatry where the consultant psychiatrist is placed at the top, the rest of the professionals occupying the step below and the service users lying at the bottom as recipients of care. For instance, Care Receiver 4 described how:

When I speak to the nurses about my medication, they inform me that they have to do what the doctor says. They say that the doctor wants me to have it and so they will give it to me even if I do not want to. [CR4:22]

Finally the construction of the relationship in terms of a vulnerable care receiver and a heroic professional may be classified as **romantic discourse**. The narratives elicited by the care receivers whose discourses form part of the *Satisfaction-Acceptance* theme, were, in certain instances characterised by a rosy picture where the professional was seen as gentle and benevolent. During the interviews, it could be noted that when care receivers engaged in romantic discourse, they communicated affection and satisfaction in terms of the *Satisfaction-Acceptance* therapeutic alliance and the professional within it. Although fondness and respect was perceived when all care-giver types were discussed in this alliance-type, it was clear that the doctor was seen as the most knowledgeable and powerful figure in the system. As an example, when Care Receiver 2 was talking about his consultant psychiatrist, he stated that:

If one disagrees with the psychiatrist, I think that the psychiatrist would say: “I am the one in command here”. But my psychiatrist is not like that...he is nice. [CR2:27]

The dominant discourses that have been identified in the care receivers' narratives present a number of subject positions within this discursive theme. As a starting point, the compliance discourse that emerged from the care receivers' words may offer a subject position characterised by affinity for traditional norms, values and practices as well as partial submission. Care Receiver 4 provided a good example of this by stating that:

With the nurses: I have less power than they do. They are in command here. [CR4:26]

This morning I was given a punishment (*by the nurses*) for not taking the pills - I was not allowed to go to mass. Mass is my religious belief. [CR4:36]

Later, the same care receiver followed up the above statement by saying that:

With the nurses, I feel good. Sometimes I buy things for them too. [CR4:23]

This description of events provided by Care Receiver 4 resembles the three leading tenants in the exertion of power as identified by Foucault (1979/1995, p.170). In this instance it seems as if the care receiver was first observed – *Hierarchical Observation* (noted to be refusing the pills). This was followed by punishment – *Judgement* (by the professionals who decided that it is wrong to refuse pills) and *Normalisation* (not allowed to go to mass in order to force him to normalise his behaviour). During the same process, he was also being assessed – *Examination* (classified as 'behaving badly' and punished).

In view of the fact that the interview with this particular care receiver was characterised by general anger brought about by feeling oppressed by the psychiatrist, the above excerpts come across as surprising. This is due to the fact that the care receiver is aware of the power imbalance within the alliance that he has with the nurses. Yet, unlike his attitude towards his alliance with the psychiatrist, he seems ready to accept this fact and is still satisfied with his alliance with the nurses. As already alluded to, it is quite striking that in a Maltese health care system where the move is towards less restrictive care and service user involvement, most of the care receivers who were engaged in *Satisfaction-Acceptance* alliance-types seem to

prefer the time-tested ways of practice, with little regard for their effectiveness. However, on reflection, this stance may lead to an important gain, namely, the feeling of security. One can identify with this need for feeling safe especially in the case of a person whose life may have been affected by the unpredictability of mental illness and its consequences. It is not surprising that this has been addressed in detail in existing literature on the experience of symptoms related to mental illness. User narratives such as those presented in the book *Unquiet Mind* by Jamison (1995) clearly depicted the devastation that mental illness can cause in a person's life. Additionally, the author of this book asserted how a psychiatric and pathological understanding helped her to feel secure. I feel that this can be related to possible feelings experienced by care receivers in the *Satisfaction-Acceptance* alliance-type: a constant and predictable environment may be safe and in the same manner, tradition and a rigid hierarchical system may also provide security for these individuals. This postulation reflects the feeling that I had during the interviews, which mainly revolved around the observation that this group of care receivers seem to feel safe and that this safety plays a major role in their perception of the alliance. However, one needs to ask: *what are the care receivers trading for the acquisition of this security?* In reality, it seems as if the main compromise that is being made from the care receiver's part is the right to be an equal partner within the alliance as well as the acknowledgment that s/he may be the holder of expertise knowledge that may benefit care. It is wondered then: *does this mean that the care receiver is being oppressed?* It is not easy to obtain a simple answer to this query, however, it is clear that there are probably other mechanisms that are in action and oppression may not necessarily form part of the equation. For instance, one such tangent may view the care receiver as being knowledgeable and motivated but has simply decided to exert his power on maintaining tradition. Hence, this may prompt the revision of the word 'compromise' that has been mentioned earlier in this argument. Perhaps that which appears as a 'compromise' is in fact a wise choice based on a different kind of knowledge that has guided the care receiver to simply strive for long-term security and satisfaction rather than equal partnership within the alliance. For instance, in the following excerpt, Care Receiver 7 discussed how a power imbalance within the alliance enhances clarity and possibly maximises therapeutic outcomes within the alliance:



I feel as if I am less than them (*the nurses*). I have less power than they do. That is quite clear. It has to be like that otherwise we would become friends with the nurses and it would all get mixed up. [CR7:30]

Indeed, during the interview, there was no hint of the care receivers feeling as if they were undertaking any major compromises or of being overly passive. On the contrary, all the care receivers who had *Satisfaction-Acceptance* alliance types viewed their readiness to participate in the alliance and to provide feedback to the professional, by stating that:

If I disagreed with something that she said, or had any feedback to give her, I would do so. Like this morning, as a case in point – she (*the occupational therapist*) asked me to wash a few clothes and I reasoned that when you go home, they are not the only things that you have to wash. [CR5:29]

I would speak up if I did not agree with anything that they (*the nurses*) said. [CR4:23]

So I discussed this with my therapist and asked her to forward my opinion to the consultant psychiatrist. [CR6:17]

I am sorry about what I did yesterday. But it was necessary because they were mocking me. I wouldn't have thrown anything at them - just at the cooker. They were nice to me afterwards. [CR7:25]

Nevertheless, the care receivers' insistence that the steering wheel remains in the professional's hands was clearly enmeshed within this readiness to be an active participant within the alliance. In this light, it may serve to examine whether in the same instance as security is being offered to subjects in this position, it may also be giving the care receivers an element of control. This type of control arises from the familiarity and predictability of a rigid traditional system as opposed to one that is characterised by change and flexibility.

Another perhaps less complex angle related to the position created through the use of compliance discourse is that this type of discourse is brought about by the possibility that care receivers have simply become used to the traditional ways of practice as dictated by a medical model. This implies that, for instance, the care receivers expect the doctor to be the withholder of power in the medical hierarchy and that other

members of the multidisciplinary team occupy lower levels but still have the knowledge and authority to manage the life of care receivers under their care. This is to say that care receivers may not know any system other than this and so they are accepting, living and practicing that which to them feels as being ‘the norm’ within that particular alliance. In simple terms, *ignorance is bliss*. In particular, this was exemplified by Care Receiver 9 who described how:

The nurses have to obey the psychiatrist - it is protocol; they cannot do anything else. If the psychiatrist says that I can only go out with my husband for a few hours, then this is what they are going to do. It is useless me asking them if I can go out with my daughter. The nurses do not have any say. [CR9:31]

It may be particularly useful to view this against the backdrop of cultural traditions in which this study took place. As discussed in the introductory part of the thesis, this is an island which is inherently quite conservatist in nature and this includes a tendency to abide to power hierarchies that are rigid and clearly structured. Thus, for example, the doctor figure holds a lot of respect, power and importance not only in professional practice but also in everyday life. Perhaps then it is not a wonder that this group of care receivers seem to be satisfied with trusting all aspects of care in the hands of the professionals. In his genealogical process undertaken in *Madness and Civilisation*, Foucault (1961/2001) discussed this notion when he mentioned the appearance of the doctor figure (p.261). He contended that in this manner, madness was adopted by the medical discipline and the authority of scientific power normalised the fact that the doctor is the most powerful figure in the hierarchy.

Finally, it has to be mentioned that this position may also offer a shift in the loci of responsibility. This refers to the perception that since the professional is the leading figure in the alliance, s/he is also the entity which is mainly responsible for decision making and for care outcomes. Simultaneously, this may conveniently free the care receivers from taking responsibility in their own recovery. Here, it has to be mentioned that it appears as if this responsibility shift is partial and not complete, as indicated by the motivation and semi-autonomy exhibited by most the care receivers who have one or multiple *Satisfaction-Acceptance* alliance types.

This can be contrasted with the moderate-to-high care receiver passivity and dependence that is evident within most of the alliances in the *Dissatisfaction-Compliance* alliance-type which will be explored in the subsequent theme and which mainly leads to one-sided responsibility within the alliance. Still, this willingness to regard the professional as the leading figure in the alliance feels similar to something which I am calling *self-induced paternalism*. In their article about advocacy and paternalism, Thomas and Bracken (1999) asserted that “the days when patients gratefully tugged their forelocks and deferred to the doctor's superior knowledge and social status have gone.” (p.327).

Apparently not - at least not in my study. Thomas and Bracken (1999) proceeded to describe how paternalism may be beneficial if it is in the care receiver's best interests (p.327). However this may introduce the risk of confusing the professional's wishes and expectations with those of the care receiver's, which may not be similar. Perhaps this self-induced paternalism is also akin to Foucault's contention that it is possible for an individual to both have power and yet be constrained by it (Foucault & Gordon, 1980, p.98). Thus in this case, a predictable system with a responsible medical figure in the lead may be a source of power for the care receiver within a *Satisfaction-Acceptance* alliance. At the same time, the care receiver may also be constrained by this power due to the accepted position of being somewhat unequal to the professional.

The second discourse identified – that of romantic discourse, may give rise to a position that introduces an element of hope and the concept of ‘love’ within the realms of the therapeutic alliance. It has to be noted that this does not necessarily refer to love that originates out of sexual attraction or infatuation but rather to a kind of *professional love* in an alliance that is characterised by warmth and serenity. Here the care receiver seems keen to attest that the therapeutic alliance is a special and unique bond in which the professional features as a wise and loving individual who makes an extraordinary effort to offer protection, as exemplified by the following excerpts:

With the nurses, I feel good. Sometimes I buy things for them too. [CR4:23]

But my psychiatrist is not like that...he is nice. [CR2:27]

He (*the psychiatrist*) is like a father to me. He guides me and makes decisions that will help me to get better. [CR10:30]

They help me, the professionals and the consultant psychiatrist, they always try to make things better. [CR6:23]

In this type of alliance, the professional is often attributed the value of a family member or significant other. Primarily, it is felt that in this position, the care receiver may harbour an element of excitement and purpose. This may be fuelled by viewing the recovery process as an adventure in which each interaction within the therapeutic alliance is awaited with a degree of expectation, as one would if s/he were interacting with a loved family member or friend.

It is not hard to unearth the possible rationale beneath this viewpoint when considering the positive feelings that romantic discourse may instil within the care receiver. By placing the knowledge-power bundle within the professional's hands, the care receiver may simply be attempting to secure unconditional love and protection. In a similar manner to the compliance discourse that has been discussed previously, perhaps this care receiver attitude is related to the cultural tendency to view professionals, in particular the doctor figure, as individuals who are complete experts and who have all the knowledge that is needed to protect individuals under their care from the distress that they may be experiencing. As already discussed beforehand, there is no hint within the care receivers' narratives that indicates that the care receivers feel as if they are being compromised. Conversely, the participants appear to be at ease with allowing the professionals to dictate care and guide the way. Foucault (1961/2001) attributed this type of discourse to the influence of positivism in medicine:

As positivism imposes itself upon medicine and psychiatry, this practice becomes more and more obscure, the psychiatrist's power more and more miraculous, and the doctor-patient couple sinks deeper into a strange world. In the care receiver's eyes, the doctor becomes a thaumaturge: the authority he has borrowed from order, morality...it is because he is a doctor that he is believed to possess these powers (p.261).

Despite the positive aspects that characterise this scenario, one cannot help but to speculate on two major potential losses for care receivers. The first query revolves around the notion of *transference* and the possibility that the care receiver may be attempting to fill significant voids in his/her life by shining a romantic light onto the therapeutic alliance and the professional within it. However, as discussed in the previous chapter, Freud (1915/1989) believed that transference may not necessarily be a drawback in therapy if it is managed in a professional manner (p.496). This leads us to the second dilemma which acknowledges that the professional is a human being and not a hero. At this point, I feel that a glance at the conceptual analysis carried out about *heroism* by Franco, Blau and Zimbardo (2011) may be insightful. Following exploration of the concept of heroism, the authors defined heroism as a social activity that is:

(a) in service to others in need—be it a person, group, or community, or in defence of socially sanctioned ideals, or new social standard; (b) engaged in voluntarily; (c) with recognition of possible risks/costs; (d) in which the actor is willing to accept anticipated sacrifice, and (e) without external gain anticipated at the time of the act (Franco et al., 2011, p.3).

In view of this definition in the context of a therapeutic alliance, I am concerned by a number of challenges that may be encountered. The first problem that I foresee arises from the fact that the therapeutic alliance is a working tool and the professional in it may not be situated there by choice – this is in agreement with points (a) and (c) identified in Franco et al.'s definition but contradicts point (b). Moreover, the same definition outlines the willingness of the *hero* to accept sacrifice without external gain – once again, the therapeutic alliance is not felt to be necessarily linked to this need. Moreover, the working alliance may function against a set of rules and so it may be subject to changes such as, for instance, the professional changing job. This may lead to extreme disappointment from the care receiver's side since the accompanying feeling may be that of being let down or abandoned by a heroic loved one. Similarly, the voluntary relinquishment of power within the alliance is felt to introduce a vulnerable wedge where the professional may adopt an inflated sense of importance - a heroic rescuer - hence failing to manage transference in a professional manner which may not necessarily add any benefits to practice. As contended by Rogers (1961) the danger is that such practice may probably be focused on treating,

curing or changing the person rather than allowing the alliance to be used as a medium for his/her personal growth (p.32).

## **Conclusion**

On a final note, this theme is felt to introduce an interesting view to the analysis of the discursive object. This is a theme characterised by dependence on traditional systems of care which are not considered as ideal practice by contemporary standards. However, this alliance-type features a group of care receivers who are mostly satisfied and who view their alliances in a positive light. Perhaps here, it is vital to attempt to measure whether alliance satisfaction automatically translates to beneficial care outcomes or if this tangible serenity within the alliance is simply a reflection of covert institutionalisation.

## **Theme 2: The Dissatisfaction-Compliance alliance-type**

### **Introduction**

Five out of the alliances identified from the care receivers' interviews were classified underneath this theme.

This type of alliance shares a number of features with the *Satisfaction-Acceptance* theme. In fact, on encountering this type of alliance, it had been tempting to associate it with the first theme because both present a knowledge-power balance that is mostly shifted onto the side of the professional. However, it is felt that opting to merge these two themes would have resulted in the omission of a number of observations that came to light during the analysis of the care receivers' narratives and the professionals' texts.

At first glance, the *Dissatisfaction-Compliance* theme depicts an alliance where the professional seems to be in the lead by exercising expert knowledge in the management of the alliance and indeed, in all aspects of care. Although this scenario bears resemblance to the *Satisfaction-Acceptance* alliance, the main difference lies in the care receiver's involvement and satisfaction. Thus, the *Dissatisfaction-Compliance* alliance is characterised by a care receiver who is accepting the power

imbalance within the alliance as it is but is simultaneously implying a degree of dissatisfaction with certain features in the alliance. Moreover, the role of the care receiver in this scenario is an individual who seems to be mostly relinquishing active participation in favour of dependence on the alliance as steered by the health worker. Thus, for instance, all of the participants within this alliance-type portrayed their reluctance to provide feedback to the professional concerned in preference to follow his/her guidance without questioning.

## **Discussion**

In order to initiate the exploration of this theme, the discursive constructions of this type of alliance shall first be discussed. Notably, the primary reference to the alliance was made by describing a relationship where the care receiver perceives a powerful professional who should be obeyed:

I do not think I would tell the nurses if I disagreed with what they said. [CR5:31]

He (*the psychiatrist*) tells me what is needed and I try to do what he says. What he says goes because it is for my own benefit. [CR5:27]

The alliance is at times viewed as being a medium of fear and sometimes a catalyst to the employment of sanctions such as:

If I do not agree with something that the nurses say, I do not always tell them because I am afraid. I am afraid that they will stop something - stop one of the permissions. It has never happened to me but I have seen it happen to other care receivers. [CR2:28]

What can I do? I had said something to the nurses and they said that I have to take it unless I wish to stay here forever. That scared me and I was also scared that they would give bad feedback to the doctor. [CR10:23]

I am scared when I am with the psychiatrist. I am scared about what he is going to tell me. [CR5:27]

Finally, some of the participants who are part of *Dissatisfaction-Compliance* alliances, seem to construct the relationship in terms of outcomes that can instil displeasure or discomfort. For instance, Care Receiver 1 described how:

There are two nurses here whom I do not really like but the rest are fine. Because sometimes they joke with me but I would not be in the mood for joking. And I do not realize that it is a joke. [CR1:57]

Similarly, Care Receiver 5 spoke about her alliance with the psychiatrist and stated that:

The psychiatrist decided about the care plan. Only the doctor decided. And when they tell me that the doctor has decided that I should go home for an extra day, I get a shock. [CR5:17]

This journey through the different discursive constructions of the alliance as portrayed by the participants, shows that a number of discourses are visibly contributing to the nature of this type of alliance. Following the same pattern in the other themes, one may first consider the discourse-types that are being employed by the care receivers. As already indicated by the discursive constructions that have been presented, the picture is partly dominated by apparent passivity and dependence. This is felt to be directly linked to **compliance discourse**, which is depicted as a high degree of submission to the traditional and hierarchical medical model. In a similar manner as that seen within the *Satisfaction-Acceptance* theme, a number of care receivers viewed their perception on the psychiatric system by stating that:

The professor decides about the pills, he gives them to you eh. He is there to help you. You have to take them as they give them to you. [CR5:18]

But sometimes when I ask, they (*the nurses*) say: "That's what the doctor has prescribed!" [CR5:22]

But I guess it is the way the system works, the way it has always worked. So I do not really question but go along with it. [CR10:14]

Additionally, it seems as if the participants are engaging in another discourse type that is here being termed as **discontentment discourse**. This features as a direct or



implied reference to not being satisfied and comfortable with certain aspects of the alliance. For instance, Care Receiver 5 made a reference to her displeasure at the feedback that was given about her by the nurse:

Yesterday there was this nurse who asked who is going to lay the table and I volunteered. Then she told my husband that I am trying, I do the effort. But slowly. And I hate 'slowly'. Always slowly. [CR5:32]

Similarly, Care Receiver 2 clearly outlined his perceived lack of fulfilment in his alliance with the nurses:

I relate to nurses when for instance, I ask them for some hot water to make coffee. Nothing special. Nurses do not offer any treatment or try to help with the symptoms. I never had any relationship with any nurse where I disclosed my feelings or talked about my symptoms. We just speak about stuff related to computers. [CR1:59]

The discourses that care receivers in this type of alliance engage in, offer particular subject positions to these participants. The positions that are created through compliance discourse have already been elaborated on in relation to the *Satisfaction-Acceptance* theme. On a brief recollection of what was discussed in this previous theme, this is a position related to strict adherence to traditional view points and practice from the care receiver's side. Complementing tradition, this is also a position that dictates acceptance of a perceived or actual hierarchy. In this case, the participants who are found within this position view their interactions with the psychiatric system as being shaped and needing to be religiously guided by the medical model. This latter model portrays the medics as the experts who withhold the superior knowledge and exercise the power that this knowledge lends to them (Szasz, 2010, pp.18-19). Moreover, the individual seems to be lacking the acknowledgment that s/he has the potential to offer any contribution within the alliance or that s/he possess a different kind of knowledge that is as valuable as that possessed by the professional. Consequently, Laing (1960) asserted that this is commonly engrained within a mechanism or care system where the care receiver's preferences and knowledge do not hold a key role in the therapeutic alliances that the care plan is based upon (pp. 41-43). In a similar manner to the *Satisfaction-Acceptance* theme, this type of discourse may give rise to a package of feelings and a

roadmap to actions and behaviour within the therapeutic alliance. The main feelings identified within the participants' discourses are that of security and stability as based on an attitude of high dependence on the psychiatric system and the expert professional. Here I feel that the 'sick role' may be another discursive position that is created by compliance discourse – an examination of the narratives of participants who are part of this alliance-type features common references to feeling sick, weak and helpless. For instance, Care Receiver 1 stated:

Then I lose hope. I lose heart a lot. [CR1:51]

Care Receiver 5 also confessed that:

If at the time that I had that beach incident, I would have known about all the admissions that I would eventually have, I would have tried to drown myself. Because you get fed up of being admitted one time after the other. Even people with physical disabilities seem to be able to do things whilst I can't. It is like someone is stopping me from doing things. [CR5:11]

The sick role - a concept formulated by Parsons (1951) is a role in life that is governed by one's illness and its actual or perceived consequences (p.452). On referring to the participants of the study, it can be noted that in a therapeutic alliance where the care receiver is in the sick role position, it implies that s/he needs constant support. This support may be particularly but not exclusively from expert professionals who can offer and confirm an explanation in relation to the symptoms and prescribe treatment. Invariably, this creates a degree of dependence on those who deliver the needed care and support.

On reflecting upon this position, it can be noted that identifying oneself with sickness may be linked to the care receiver making use of superior knowledge that leads to latent power and gains within the system. As an example, Parsons (1951) explained how the knowledge that sickness usually attracts pity and sympathy, can motivate a person to remain fixed and inactive within this role due to the person's appreciation of the reactions and support being offered in terms of his/her illness (p.452). Similarly, the sick role may also offer the opportunity of acquitting responsibility for actions and behaviour that would otherwise be less tolerated. Hence, in this scenario, it can be observed that power may be fuelled by the

knowledge about the gains related to mental illness and to the therapeutic alliance. This phenomenon can also be understood in terms of dependence and care receiver passivity in the context of the therapeutic alliance – this is because decision-making equates to responsibility. On the other hand, if the other party in the alliance is the sole entity engaged in decision making, this may automatically imply that it is also this same entity which is ultimately responsible for the outcome of decisions. Foucault (1982) attributed this to what he called *techniques of the self*. This refers to the fact that an individual may not simply be a passive product of power relations but he may also be choosing how to act and thus exerting power upon himself/herself: “techniques that permit individuals to effect, by their own means, or with the help of others a certain number of operations on their bodies and souls, thoughts, conduct, and the way of being, so as to transform themselves” (p.18).

Discontentment discourse outlines a number of subject positions which are centred around the fact that the care receivers within this alliance type feel as if the alliance is lacking in one way or another. As a case in point, Care Receiver 5’s experience of being in this discursive position is linked to a feeling of patronisation as implied by the following excerpt:

Mostly it is “Hello” and “Thank you” with the nurses. Sometimes I open up with them but they say: “You will get better. You have a husband who loves you and respects you. Be brave so that you get out of here.” [CR5:31]

Contrastingly, Care Receiver 1 communicated an aura of detachment within the alliance by describing how:

At the moment, I have a nurse who is with me all the time because I told them that I wish to die. Sometimes I would not even know who the nurse allocated to me is. They do not let you know, they do not say anything. Then I realise who it is because this nurse keeps following me. [CR1:58]

As previously exemplified by Care Receivers 2 and 10, the feeling of being scared can also be part of the experience of discontentment discourse. In these care receivers’ case, their fear arises from their perception that professionals may punish them and so, as a preventive measure, they choose to be compliant within therapeutic alliances. Foucault’s ideas on the notion of punishment may shed light on this

finding. In *Madness and Civilisation*, the philosopher compared the behavioural treatment techniques used in the nineteenth century (such as the ‘stopping of permissions’ mentioned by Care Receiver 2 in this study) and the physical punishment that had been popular in earlier practice (Foucault, 1961/2001, p.262). Foucault’s conclusion highlighted the fact that despite the difference in nature, both techniques concurred with control and restraint: the main change was in the application of power: from overt to covert.

On taking a collective glance at these two discourse-types and the subject positions that they offer, a number of points call for attention. The first observation is linked to that which is felt to be the main loss for care receivers who are part of a *Dissatisfaction-Compliance* type of alliance. Whilst relinquishing the responsibility related to decision-making and active participation, it seems as if care receivers are giving up their independence, their autonomy and their appreciation of self-worth. Incessantly it feels as if in these alliances, care receivers are acting on a self-label that reads: *No knowledge, no worth, no power, no say*. Moreover and more of a concern is the realization that in this alliance-type, care receivers are particularly vulnerable since they do not have the shield of autonomy and dignity which may otherwise lend an element of protection. Funnily enough, despite the fact that the participants are not overall satisfied with some of the elements in the alliance and in their care, they seem to accept this situation and do not have any particular desire for change. This was specifically inquired for during the interviews and two notable replies were:

I am fine with the idea that I have less power than they (*the nurses*) do. It is how things should be. This is because they are the ones in charge and know how things should be done, not me. [CR1:67]

The nurse always has to be on top and so has the psychiatrist. Because they studied to be like that. I believe that they should be on top and I just trust in them. [CR5:40]

Perhaps it is not surprising then that within this alliance, this group of participants unanimously agree that they would not forward feedback to the professional even if they disagreed with aspects of care such as treatment decisions. In the case of this

theme, this apparent acceptance and lack of readiness for change does not automatically translate to the same satisfaction and peacefulness that was evident in the *Satisfaction-Acceptance* theme. Contrastingly, the feeling that I had during the interview when participants were engaging in discourse related to the *Dissatisfaction-Compliance* theme was one of passivity, pessimism and dependence, falling underneath an umbrella of institutionalisation and adherence to tradition. On reflection, it becomes apparent that this type of alliance may be a direct creation of a system that is still rooted in medical monopoly and which may not be particularly effective in preventing institutionalisation in those who are at the receiving end of the services. It may also be linked to the cultural tendency in Malta to protect the vulnerable and to reach out to those in need. Oftentimes, this features as a paternalistic attitude which, albeit being benevolent in its intention, may at times harbour an element of helplessness and inability in those at the receiving end. It is perhaps then not surprising that this group of care receivers may be perceiving themselves and their situation in a passive and negative light but yet do not show any strong will to change the *status quo*.

In view of this possibility, I am reminded of the television set analogy made by Szasz (2007) when he contested the idea that psychiatry can treat psychological problems (p.6). In Szasz's opinion, state services (such as those offered by the hospital involved in my study) are ineffective and undesirable because they tend to limit the individual's freedom (Szasz, 2000, sec.3). This may be surprising in view of the trend towards community care as a mainstream service in lieu of inpatient psychiatric care. However, it has to be noted that whilst the idea of a community care model is in itself, a promise for higher regard for care receiver autonomy and probably a more balanced alliance-type, the effectiveness of this model is highly dependent on a number of factors. Prominently, the perceptions and attitude of the care giver and care receiver in therapeutic alliances in community services may be vital in the practice of recovery-based 'community psychiatry' as opposed to the formation of a 'psychiatric community'. The latter term points towards an extension of the institutionalization process seen in some inpatient settings – an approach that defies the very scope and perceived value of offering care outside the psychiatric hospital. This phenomenon was given prominence by Basaglia (1964) who was

particularly concerned that the beliefs, attitudes and culture of the asylum may be easily reconstructed in community services under total control by the doctor (p.5).

On reverting once again to a collective glance at this theme, the second observation that has emerged involves that which is felt to be another crucial difference between the *Dissatisfaction-Compliance* and the *Satisfaction-Acceptance* alliance-types. A look at the former type of alliance highlights the fact that here, the care receiver and the alliance itself may be quite highly dependent on energy input from the professional. On the other hand, a *Satisfaction-Acceptance* alliance involves a care receiver who albeit exhibiting trust and a level of dependence on the professionals, may still embrace and enjoy a degree of autonomy and independence. Thus this may indicate a difference in the energy source between the two alliances – main reliance on the professional as an external energy source (in the *Dissatisfaction-Compliance* alliance); a tendency to contribute to the momentum of the alliance (in the *Satisfaction-Acceptance* type).

### **Conclusion**

Since this study was not a longitudinal one, the long-term outcomes of the *Dissatisfaction-Compliance* type of alliance could not be adequately explored. However there seems to be a clear possibility that such an alliance may eventually lead to chronic care and institutionalisation brought about by overly dependent states such as those seen in the ‘revolving door syndrome’ or ‘psychiatric communities’.

## **Theme 3: The Resentment-Opposition alliance-type**

### **Introduction**

This type of therapeutic alliance was linked to five alliances which were perceived and talked about by means of consistent discourse-types falling underneath this theme.

This therapeutic alliance-type is mainly characterised by a one-sided alliance where the care receiver perceives the professional to be on the upper side of the knowledge-

power interface within the alliance. Consequently, it feels as if this alliance type may be dominated by a continuous power game between the care provider and the receiver.

## **Discussion**

This theme is very distinguished from the rest in that it has very specific characteristics. On shifting the light on the interviews that were carried out with the care receivers, the emotion felt was strong, highly tangible and unpleasant. It was evident that the most of the participants' demeanour was one of anger and discomfort brought about by a power imbalance in favour of the professional within the alliance. These were individuals who at times showed clear disagreement with care plans and felt as if their rights were not being respected. As a result, some of the participants actively chose to resist care in their determination to not let the system get them down - self-declared fighters:

I had permission to go to the main garden accompanied. But I refused to take the injection and he (*the psychiatrist*) stopped my permission. He wanted to give it to me against my will. [CR4:16]

Contradictingly, some of these care receivers were also felt to convey a sense of hopelessness in the face of a care system that was perceived as oppressive and even harmful. As Care Receiver 1 commented:

I am not happy with the care that I am being given. I am not happy with this environment either. I cannot do anything about this – I just want to go home for some peace. [CR1:39-41]

On reviewing the narratives produced, it is almost as if the whole experience of mental illness, hospitalisation and the process of being in an alliance with different professionals is at times constructed as a struggle - a challenge and a power game that seems to favour the professionals. In Care Receiver 4's terms:

Here it is always a struggle with the doctor because I do not want the medication because it harms me. [CR4:31]

Similarly, Care Receiver 9 shared her experience of her alliance with the psychiatrist:

My psychiatrist does not give me enough information on my symptoms. Now just this morning he told me: “We’re not going to do the ECT and we’re going to stay without the pills and you need to make an effort.” TELL ME WHAT I HAVE! [CR9:10]

On the same lines, the alliance is at times perceived as being a punishment tool – a medium that strips away the care receiver’s rights and allows the enforcement of oppressive measures. Care Receiver 4 exemplified this by describing how:

The junior doctors visit but they say that they cannot give me any permissions because they speak to the consultant psychiatrist and he does not wish to give me permissions. He does not even come to see me once weekly. I speak to his doctors. [CR4:16]

In the same manner, some participants constructed the alliance as being a mystery – a set of interactions that are shrouded by unexplained events, unanswered questions and strange decisions. Care Receiver 9 spoke in detail about this and at one point, she exclaimed:

But then, provide me with someone who can help, someone who can say: “You are doing this and that which are not right and if you do this, it will help you.” Guide me eh. Because I do not know what I need to do. [CR9:17]

A final discursive construction that was evident in this theme paints the therapeutic alliance perceived by the care receivers as being an unwanted burden and one that is definitely there on a temporary basis without any evidence of therapeutic outcomes. During her description of the alliance with the psychologist, Care Receiver 7 provided a good example of this by stating that:

The psychologist does not help me. I feel embarrassed when I am with her. Because I know that she doesn’t want to deal with me, you know. I feel it strongly. Very very embarrassed, I hope I do not see her again. [CR7:28]

Along the same line, Care Receiver 6 spoke about her alliance with some of the nurses:

The nurses do not give me any therapy. Patients do not speak because nurses snap at them and that destroys all the trust. They (*the nurses*) need to speak to you not tell you the contrary. [CR6:35]



On the basis of these constructions of the therapeutic alliance by the care receivers and their carers, it can be seen that a number of discourses are being employed. As already evident through the excerpts that have been included, **anarchist discourse** was the dominant discourse-type in those care receiver interviews that contributed towards the emergence of this theme. In this view, the care receivers are rebelling against authority or the perceived ‘ruling power’, which in this case, is comprised by the psychiatric discipline. The tone, the choice of words and the overall characteristics of the narratives suggest care receiver unity in a movement that opposes hierarchy due to the perception of this authoritarian body to be harmful and unnecessary.

Care Receiver 1 may have provided a clear example of this phenomenon by stating that:

They throw you into this room, as if you are in prison – seclusion - and you feel even more down than you already are. [CR1:18]

Later he added:

And they are totally decided that the problem is the alcohol - that irritates me. The real problem is the way I feel and then I drink so as to detach myself from reality. I think that I had spoken about this to my psychiatrist once. But he just kept insisting that I need to enrol into the rehabilitation programme. [CR1:60]

In this regard, resistance seems to be playing a major role within some of the *Resentment-Opposition* alliances encountered as portrayed by a care receiver who does not view the alliance as a basic and fundamental part of treatment but holds the notion that s/he needs to be vigilant and constantly ensure that s/he is not being abused.

The discourse pertaining to this discursive theme is also akin to **discontentment discourse** which has already been encountered in the *Dissatisfaction-Compliance* alliance-type. However, in the *Resentment-Opposition* theme, the discourse used often extends beyond the expression of mild displeasure and culminates in intense anger or a perception of the alliance as being hopeless. Thus, unlike the

*Dissatisfaction-Compliance* theme, most care receivers in a *Resentment-Opposition* alliance-type do not simply express displeasure at aspects of the alliance and stop at that. Contrastingly, most of these care receivers resist the very alliance and the care that it may provide, as shall be discussed later. The following excerpt may serve as an example of this attitude:

My role in the multidisciplinary team is to dread each ward round because it means a change in medication. I do not have any importance within this team. I know how to keep myself clean and the house clean. By bringing me here, they have made me lose the opportunity to live my life. All my life.  
[CR4:21]

Following the identification of the constructions of the therapeutic alliance and the dominant discourses within this discursive theme, the subsequent step is to reflect on the subject positions offered by the discursive constructions and the related discourse-types. Moreover, the area enclosed within these subject positions shall be explored in relation to the subjective experience of being within each position as well as the norms and values dictated in this instance.

At this point, it is felt fruitful to commence the argument by discussing my subjective experience whilst participating in the interview with care receivers whose narratives featured the alliance-type that is being described in this theme. Of all the care receivers who were interviewed, this group of care receivers were the ones who held my utmost interest and this led to many hours of reflection and re-listening to the recordings. I have to confess that this interest was primarily fuelled by the fact that the main feeling that I had during the interview with this group was one of discomfort and unsettlement. Additionally, I also found myself in a position where I was vividly aware that at that moment, I had to maintain my role as a researcher and thus refrain from side-stepping into a clinician's role. Afterwards, I concluded that these feelings were related to my perception that the participants were possibly utilising the interaction during the interview as an emotional purge - an opportunity to vent out, to make their voice heard and to possibly undergo catharsis. This led me to wonder what it must be like to be a care receiver within these types of discourses.

Since discourses peppered by anarchism and discontentment are felt to be interlinked, it may be useful to consider the collective rather than the individual

positions that they give rise to. On viewing the care receiver situated in these positions, the image that may be seen is that of a survivor. Here, this word is being used in the same sense as implied by the critical psychiatry survivor movement. This relates to service users who rebel against psychiatric practices that are mainly based on the medical model (Knight & Kierans, 2011). Indeed, it has to be said that the care receivers' narratives echo some of the writings of prominent figures in the anti-psychiatry and critical psychiatry movement, with the same vibes of anger and frustration at the medical world. This position may offer a sense of being active and fighting for one's right as well as opposing a scientific discipline that may be perceived as having monopolised and pathologised the field of mental health. The displeasure and discomfort that has been communicated by the care receivers during the interview is seen to be a dominant characteristic and particularly brought about by lack of care choices and participation in care. The discussions that I had with care receivers who were part of a *Resentment-Opposition* alliance featured a range of scenarios where the care receiver felt as if s/he were not being offered options and as being excluded from decision making. Prominent statements included:

The only treatment option that they offered me at that time was admission to the hospital. I did not agree with them that I needed to be admitted or with the way things happened. I am not sick or mental. [CR4:7]

I am not satisfied with the treatment that I am receiving here. I try to speak to the doctor about it but he ignores me. He does not wish to speak to me. Nothing. He does not pay attention. [CR4:15,16]

My care plan consists of antidepressants and Valium because of the drinking - those basically. And you spend the day staring aimlessly and smoking. [CR1:26]

Most of the discussion is not directed at me – most of the discussion is directed at my husband, the psychiatrist wouldn't be speaking to me. He would be speaking to my husband. So I stay there listening to them talking about me. [CR9:18]

Complementing this perception, it seems as if the majority of the care receivers in this type of alliance feel as if they are not being respected or treated as an equal within the alliance. In particular, Care Receiver 1 described how:

They (*the professionals*) think that you do not know how to do anything. They decide everything for you. That's not right. [CR1:32]

Similarly, Care Receiver 4 expressed his displeasure by describing his perceived role in the alliance with his psychiatrist:

With the psychiatrist, I feel like dirt. He does whatever he wants to. Even when I let him know that the medication is harming me. [CR4:27]

In her *Resentment-Opposition* alliance with nursing staff, Care Receiver 6 communicated her distaste with the disrespect that she felt subjected to:

I am not satisfied with the power balance in my relationship with the nurses. This is because they are not people who interact with patients in a gentle manner rather than a savage-like manner. This is my opinion, although I know that some others share the same opinion as I do. [CR6:33]

Interestingly, Care Receiver 7 described a situation where the perceived inequality and disrespect communicated by professionals took place in a more covert manner. In a scenario where she was describing her interaction with the psychologist, the participant stated:

I have a psychologist but she doesn't like me. I mean she is nice and would never insult me but I am intelligent enough to realise that she does not feel at ease with me. But I know from the way that she carries on that she would like to get rid of me. [CR7:24]

Conclusively, perhaps Care Receiver 9's plea can serve as a good summary of the general feelings reported by most of the care receivers in this type of alliance:

But I feel as if I am not treated as a person. I wish that they would speak TO ME. Explain TO ME. Show ME, tell ME where I'm not acting as I should, what I am doing that's wrong. Not just telling me that I am doing wrong things but not specifying what and how. And what I need to do things right. To treat me like an intelligent human being, which I think I am. [CR9:21]

This latter excerpt can serve as a springboard into a deeper exploration of the consequences of the subjects' feelings in the positions offered by anarchist and discontentment discourses. Primarily, the resulting expressed emotion during the interview was that of anger directed at the counterpart entity within the alliance – the

professionals. Once again, to me, this is reminiscent of Survivor Movement Groups which are often fuelled by anger at a coercive psychiatric system (Wallcraft et al., 2003, p.38). On further examination of these care receivers' narratives, it is visible that anger seems to be having three major consequences in relation to the participants' attitude and behaviour within the alliance. The first effect is that of resistance to care and to decisions made by the professionals. This can be seen in Care Receiver 1's case when he commented that:

I do not know anything - like when I'm going on leave, how much time I am spending here - I do not know anything. I am not going to do the rehabilitation programme. [CR1:27]

The following excerpt from Care Receiver 7's narrative serves as an additional example of resistance:

But I know from the way that she carries on that she would like to get rid of me. I would like to change the psychologist. It is ok if she is on the line but I do not want to be accompanied by her. [CR7:28]

This attitude seems to be linked to the second consequence which is the perceived ineffectiveness of the care plan. In particular, the majority of care receivers who were situated within a *Resentment-Opposition* alliance spoke about their negative opinion of the care that they are receiving in the context of the alliance:

I am not satisfied. I wish that before they prescribe medicine, they ask the patient whether he wants it or not. And the patient has every right. Because we are in the EU. The patient can decide what type of treatment he wants to have and the doctor has to co-operate with him not just force him to take medication. [CR4:30]

Actually, he just changed my pills without informing me about it. I wish that I'm involved. Because they think that you do not know how to do anything. They decide everything for you. That's not right. First of all, I wish that he (*the consultant psychiatrist*) had not stopped the Seroxat because I had been doing quite well on it. [CR1:32]

Finally, it was also observed that in certain instances, the anger and resistance give way to hopelessness - a lack of faith and belief in one's recovery and in the potential benefits of the therapeutic alliance. Care Receiver 1 made specific reference to this feeling by contending that:

When I am with the psychiatrist, I feel as if he has lost all hope in me. Now I have lost all hope too, in everything. In fact he has referred me to another psychiatrist now. [CR1:49]

Similar statements were observed in Care Receiver 9's words when she concluded that:

His (*the psychiatrist's*) opinion is that since I did such an overdose, he cannot discuss with me. And so I reflect that I may have brought this onto myself and so I have to be submissive. [CR9:35]

In view of the identified feelings that seem to accompany these subject positions, it may be useful to focus on the possible rationale behind this power game which, in terms of recent research on the therapeutic alliance, may be hindering recovery by keeping both parties in the alliance entrapped in an eternal struggle with therapeutic outcomes being side-tracked (Dziopa & Ahern, 2009, sec.9). On reflection, it seems as if these participants are indirectly exposing that which may be one of the problematic issues in the system, as revealed by some of the interviews and possibly by the majority of the medical and nursing records reviewed during the study. This involves the apparent lack of attention directed at the provision of spiritual care. In this regard, spirituality is being understood as the individual's specific blue print that provides meaning to his/her actions, experiences and path in life (Culliford, 2002, p.1). It also refers to the person's dignity, autonomy and his/her own unique identity (Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group Executive Committee, 2013, sec.2). When the participants disclosed their feelings in relation to the perceived disrespect, exclusion, inequality and lack of options within the therapeutic alliance, they could have been outlining a depersonalising and mechanical care system that fails to take individuality and holisticity into consideration. This type of care shall be examined in more detail in the section pertaining to the analysis of the professionals' texts, which notably holds hints to what may indeed be a lack of spirituality in the care provided by some of the professionals involved. Possible neglect of the spiritual dimension is a worrying issue but more so is the realisation that a number of event descriptions by the care receivers hint at a striking imbalance of power within the alliance that may be associated with abusive professional behaviour. Examples of this kind of behaviour

given by some of the care receivers in *Resentment-Opposition* alliances mainly constitute patronising attitudes, overprescription of drugs and coercion. Whilst acknowledging that the care receivers' narratives represent only one version of historical events, the following descriptions are felt to be too powerful to exclude:

In the past, I had trusted a nurse. And then we had an argument and she revealed my secrets to everyone, in front of everyone. From that moment onwards, I vowed that I would never again trust another single nurse. [CR6:27]

If you need to speak to the nurses, they should make the time to do that. But if I ask to speak to them, they should not answer: "I am busy. What do you need now?" [CR6:34]

Now the dose of Modecate that I am taking is 150mg every 2 weeks when normally they give 25mg every month. 150mg! [CR4:13]

(Note: Since Care Receiver 4's medical records were available for the purpose of this study, the medication dosage could be checked. In fact the records stated that the Modecate dose being given to the care receiver was 130mg every 2 weeks. The maximum suggested dose/frequency indicated by the British National Formulary is 100mg every 14 days (BMJ Group & Royal Pharmaceutical Company of Great Britain, 2014, p.239). In the Maudsley guidelines, a lower maximum dose of 50mg every 2 weeks is recommended (Taylor, Paton & Kapur, 2009, p.36).

Echoes and implications of these descriptions provided during the interviews are felt to outline the crucial need for further observational research, monitoring and professional supervision in order to investigate alliances in more detail. On shifting the focus, it may be worthwhile to consider another possible rationale for this morbid view of the alliance that may seem as contradictory to that just described. This refers to the possibility that despite the strong and aggressive front that these individuals exhibit to the world, they may have, for a myriad of reasons, given up on fuelling their energy and will on recovery. This may then be communicated through anger, resistance and eventual hopelessness as noted in some of the interviews transcribed. This postulates that these individuals may be caught in a vicious circle with recovery being low at the top of priorities. In this regard, the negative scrutiny of the therapeutic alliance may act as a relief from boredom, as well as a scope for-, and motivation for survival by virtue of the alliance itself being a target for anger and

frustration. Thus, in this manner, the *Resentment-Opposition* alliance-type that characterises this theme may be one that adds colour to a care receiver's life which is otherwise shrouded by darkness attributed to the various consequences of mental illness and hospitalisation. In a narrative enquiry carried out by Knight and Kierans (2011), it was concluded that by rebelling against the psychiatric system, members of a user movement group may feel empowered: "Do I stay 'user' or this person down here, or do I make major changes, and start looking at this process of stopping being this disabled, disenabled person?" (slide 9).

I feel that some of the characteristics of the care receivers in a *Resentment-Opposition* alliance may be experiencing similar feelings to those identified in Knight and Kierans' study. However, there is a major difference in that hopelessness seems to be characterising some of the care receivers in the *Resentment-Opposition* theme – this was not evident in the findings by Knight and Kierans.

## **Conclusion**

As a final concluding note to the *Resentment-Opposition* theme, one may elaborate further by pondering on whether each of the parties in the therapeutic alliance are *acting* or else *reacting* to their counterparts. Thus, one may ask: *Are the care receivers reacting to an oppressive system by exhibiting anger and engaging in a power struggle? Or are they acting in this manner due to other reasons with the professionals' actions being a direct reaction to this hostility?* Although the findings of this study suggest a mixture of both of these possible scenarios, it is felt that there is no clear answer to these questions. However, it is evident that this alliance-type seems to be mostly characterised by hostility and excessive focus on maintaining control. This suggests an unhealthy interaction and the long-term impact on recovery is a concern.

## **Theme 4: The Collaboration alliance-type**

### **Introduction**

Nine of the alliances identified within this study were mainly characterised by a scenario where the participants perceived the knowledge and power interface within the alliance as being balanced.



Here, the care receiver and the professional seem to be engaged in a partnership that is mostly characterised by dialogue and shared decision making. As a result, this alliance-type seems to be primarily governed by the mutual appreciation of different knowledge types that may be potentially contributed by the two entities within it. In other words, this is the only alliance type where there seems to be clear respect for both *expertise by profession* and *expertise by experience* as well as the equal importance of both of these knowledge types for recovery to take place. In turn, this also makes it the only alliance-type where there seems to be a balance of power, as contented by the participants who were interviewed. This results in a group of care receivers who express their satisfaction with the care that they are receiving in the context of that particular alliance.

## **Discussion**

On attending to the care receivers' narratives, it can be noted that the alliance is being constructed as an agreement based on collaboration. Care Receiver 3 highlighted this fact by his description of a typical interaction with his social worker:

When I am with the social worker, I feel very comfortable. If I give suggestions, I get feedback, good, bad - it was never bad. She will lay out the options and feedback and ask me what I think about it. I have time to discuss. I am not presented with a rigid answer. [CR3:30]

This reference to a partnership was also seen in the narrative by Care Receiver 8:

I feel very good when I am with the occupational therapist. She tells me what I'm doing wrong, tells me what's going to happen. If I disagreed with something that she said, I would go and talk to her. [CR8:24]

Notably, during the interview, an observation that was particularly evident was the switch in the whole demeanour when a care receiver spoke about the *Collaboration* alliance-type. This could be especially noted when the participant formed part of other alliance types. In this instance, the care receiver often described the *Collaboration* alliance-type against a backdrop of the other alliances in order to demonstrate the difference. As an example, Care Receiver 9 stated that:

The occupational therapist is a person who is doing that work with us which cannot be determined by the psychiatrist. And so she can do what we suggest and she respects us – that is why I feel equal, she lets me decide and participate. With the nurses, the power imbalance is due to the system – they have to obey the psychiatrist. With the psychiatrist, the power imbalance is there because I am the crazy one with no knowledge at all, I do not know. [CR9:33-35]

Similarly, Care Receiver 7 described how:

This (*alliance with nurses*) is not the same as the occupational therapists – they (*the occupational therapists*) are more like pals, you know. They say: “When you are ready, just come over and you can speak to me if you like.” [CR7:35]

In this manner, the alliance is being constructed as a beneficial and gainful system, especially in comparison to alternative alliance-types.

However, this does not necessarily imply that the care receivers have the same romantic view of the alliance as that observed in the *Satisfaction-Acceptance* alliance. Contrastingly, whereas in this latter alliance-type, the professional’s good qualities are at the frontline, with common attributions to a quasi-heroic professional, the *Collaboration* alliance-type is more focused on the care receiver’s method of managing the alliance rather than the care provider’s attitude and behaviour. As a case in point, Care Receiver 3’s description of his alliance with the nurses implies that some of these professionals are at times, far from being heroic figures:

There are ones who say unnecessary misplaced things. Like he (*one of the nurses*) said: “You have relapsed AGAIN?” [CR3:31]

In reply to this statement, which the care receiver perceived as being patronising, he said:

“Don’t you think that it is a good thing that I came here for treatment instead of staying outside in a bad way?” I did not answer rudely or whatever. I do not want to be rude. I wish to be good mannered. [CR3:31]

Thus, in this light, the alliance is a system that needs to be managed by the care receiver in order to insist on collaboration and to maintain a balance, even if the care provider’s attitude is not desirable. However, it has to be said that in most of the

*Compliance* alliance-types encountered in this study, the care receivers described the professional's attitude as being characterised by collaboration and equality.

Following reflection on these discursive constructions of the alliance within this theme, a number of main discourse-types can be identified and shall be explored.

When the entities construct the alliance as a bond that is characterised by shared decision making and respect for different types of knowledge, this can be attributed to **equality discourse**. This advocates the importance of balance and mutuality – a joint effort that promises synergy and positive outcomes. Particular excerpts from the care receivers' narratives indicate this:

The power is shared in the relationships. We are equal. [CR3:33]

I feel ok with the nurses. They talk to me, about my problems. If I am not feeling well, I have to go to talk to them. If I disagreed with something that they said or wanted to give suggestions and feedback, I would do that to the nurses. [CR8:26]

During this meeting, the nurses and the occupational therapist explain about the regulations of the place and then involve us in a discussion about anything that we would like to improve. I feel good during these meetings. [CR9:23]

This can be seen to lead the way to **assertiveness discourse** as seen by some of the participants' readiness to affirm their rights, demand respect and exhibit an aura of non-aggressive confidence in the context of this alliance-type. Notably, the care receivers' main contentions seem to be based upon the importance of a humane approach that addresses the care receiver as a unique and valuable figure. In fact, in view of the *Collaboration* alliance-type, some of the care receivers were noted to be refreshingly eager to discuss principles of autonomy, mastery of recovery and the right of selecting a tailor-made treatment package:

The way I see it, in a few years my mother will not be here. So I have to get on my feet and deal with my doctor. If I cannot deal with my doctor, how am I ever going to deal with anybody else? I can talk to the doctor and that does not affect the relationship as it may do with the nurses. [CR7:33]

However, if there is something that is harming me, I will speak up and refuse. Listen, I may look 'soft' but I stand up for myself - what's right is right, what's wrong is wrong. [CR3:26]

Assertiveness discourse may be viewed as lying beneath a perception and attitude which gravitates towards the need of freedom of choice. This is indicative of the individual's desired opportunity to pursue human rights without any encroachment from the state and the entities within it. On the application of a political stance, this may also be described as a liberal approach, with the views of the professionals and the care receivers running parallel to each other with a final convergence towards agreed-upon goals:

I formed this care plan - this was what I had told my doctor and social worker - what care plan I wanted..not going out of hospital to my home and then the programme - I want to go to the programme directly from here. [CR3:23]

What keeps this knowledge-power balance as it is, is that I wouldn't be afraid of asking questions, whoever the professional is, it can be the prime minister! [CR3:35]

The identification of these discourse types as emerging from the data collected from the narratives leads to a reflection on the collective positions offered to the entities within this type of alliance. At the forefront, the construction of the alliance through equality discourse subjects the professional and the care receiver to fair play as distinguished by the respect and positive light that the care receiver and at times, the professional, shed on this working relationship. In this discursive position, it seems as if there is acknowledgment that the other party within the alliance is as knowledgeable as oneself and each of the knowledge sources need to contribute equally in the alliance in order to allow for the maximisation of therapeutic outcomes. This seems to be in line with the Recovery Model which places emphasis on self-determination, empowerment and collaboration (Warner, 2010, p.3). On examining the care receiver side of this equation, a number of observations can be made.

The first observation in this regard revolves around the care receiver's motivation to be autonomous and independent. This does not point towards ignoring the guidance

offered by professionals – indeed, if that were to happen, it would be an act that defies the principle of *respect for the other's knowledge* which has by now been witnessed to be located at the very core of this alliance-type. Contrastingly, this refers to a situation where the care receiver is motivated and determined enough to be:

- An active participant in care
- A learner (a quest for updating one's knowledge)
- A teacher (a quest for sharing one's knowledge)
- A pragmatist (ability to use one's own knowledge in 'exploiting' the alliance in order to reach therapeutic goals)

This is felt to be a tangent to the second observation which holds that in order for this alliance to be really and truly modelled on collaboration, the care receiver needs to be willing to 'manage' the knowledge-power interface within the alliance. In this regard, effective management may be described as being shaped by the assertiveness discourse that most of the participants in this alliance-type engaged in. This is due to the fact that it is felt that in the absence of such an attitude, the knowledge-power balance in the alliance may inevitably shift the alliance towards another mechanism and covert it into any of the other alliance-types that have been described earlier on in this chapter. This point is felt to have particular importance attached to it because it is especially evident that even in the light of adversity (such as a professional who insistently promotes pathological/clinical discourse), the care receiver in the *Collaboration* alliance-type has the ability to stand firm and guide recovery. Importantly, the interview with care receivers who are in this type of alliance and who are subject to this type of adversity seem adamant to respond in a manner that is shaped by assertiveness discourse. This places the care receiver in a position where s/he acknowledges his/her right for a type of care that is more holistic and that maximises the possibility for freedom of choice. This includes the opportunity for selection of the best care package that is not necessarily one that is based on the medical model. The works by Romme and Escher (2000; 1993) and May (2005) placed the concept of *treatment choice* at the forefront of care by emphasising that spiritual and emotional crises need to be addressed by offering care options that do not force medicine onto the individual. At the same time, the care receiver in the

*Collaboration* alliance-type may find himself/herself in a position of resistance whereby s/he is assertively refusing to be shaped by traditional notions that may act to limit his/her choices. One may wonder how easy it is to be in this situation – what can be said is that most of the care receivers who were seen to employ this type of discourse did not seem to be particularly unsettled by the position offered to them. Contrarily, they seemed to take the medical model in their stride whilst striving to strike a balance within the alliance that still enabled them to use their knowledge and power in shaping the recovery process. The following narration by Care Receiver 3 is felt to demonstrate this:

But the professionals and I always got along. The power is shared in the relationships. We are equal. Like let me give you a real example: This morning I was going to mass and I had forgotten that you were going to interview me. And I told one of the nurses: “I am going to mass. And he said: “But now you have the interview and you need to speak to her.” And I replied: “But she has other people to interview, not just myself, so she can wait for 20 minutes or half an hour whilst I attend mass.” And he said: “Oh come on, what difference is it going to make to you if instead of going to mass, you stay here watching TV?” And that sparked me off. Now this is a nurse who sometimes says things in a jokey manner - he does this all the time. Like I wouldn't know what he is referring to. Then I told him: “Please do not speak to me in this manner because it irritates me and also because this is not the same manner as I speak to you. I wish to go to mass. The researcher can wait or afterall, I have a right to opt out of the interview. End of story.” [CR3:33]

Here it is worthwhile to compare this attitude as shaped by assertiveness discourse to that exhibited by care receivers in the three other themes as a response or counterpart attitude to clinical/pathological discourse. It can be instantly observed that whilst in the *Collaboration* alliance-type, care receivers seem to practice assertiveness, in other alliance-types they tend to exhibit passive aggressiveness, acceptance or dependence in the face of discourse that promotes the medical model. The rationale for this difference may be based on various contentions. Probably it constitutes an eclectic mix that features the care receiver's and professional's personality, the mental state of the care receiver, the influence of other discourses on the therapeutic alliance as well as the wider discourses employed within the health system and society.

So how does it feel to be a care receiver in the discursive positions created through the practice of equality discourse? During my interview, it seemed as if the care receivers were satisfied and proud to be part of this alliance. This is not a surprising finding in relation to the clear gains that may be attributed to respect for equality, not necessarily when viewing this concept in terms of mental health or psychiatry only but even when looking at the wider practice of equality in society.

By now, it is fairly evident that the knowledge-power nexus in the *Collaboration* alliance-type is one which can be described as being based on an even balance. This is mainly catalysed by the focus on the sharing of knowledge which facilitates active participation and collaboration by both parties. The transparent evaluation and application of suitable knowledge is subsequently fundamental in the equal distribution of power within this type of alliance. In turn, this power balance creates even more space for dialogue and collaboration which serves to facilitate the constant generation of knowledge. Contrary to what has been traditionally perceived as being one-way, this view of the therapeutic alliance depicts a partnership with possible gains for both sides. The main gain may be the feeling of unity and teamwork on working towards a common goal – an aspect that was visibly emphasised by the care receivers during my interview with them. The other gain is the growth that may be potentially experienced by both entities on gaining access to the other's knowledge and on travelling along the recovery journey. This contention is supported by Brown (2007) who used a Foucauldian approach to explore the concept of *knowing*, *not knowing* and *partial knowing* in relation to the professional's status of knowledge in the alliance. The author recognised that knowledge and power cannot be separated in the context of the alliance and dominant discourses can only be rectified if both entities within the alliance contribute actively and share knowledge (Brown, 2007, p.12). Perhaps the main loss here may be viewed in terms of the extinction of the medical monopoly due to its replacement by a vision where the professional is an apprentice within every therapeutic alliance that s/he is part of. One may argue that this does not really constitute a tragic loss – however, advocates of a purely medical approach may disagree.

## **Conclusion**

As a final note to this theme, it may be worth to pay a degree of consideration to the effectiveness of this type of alliance. As discussed, it would not be erroneous to state that if this alliance-type is viewed against a postmodern background and an approach based on the contemporary meaning of recovery, then it would probably be an ideal template. It can be noted that the *Collaboration* alliance-type shares similar characteristics to those advocated in the Recovery Model, especially due to the fact that this alliance is coloured by hope – by a perception that the recovery journey is being viewed in a positive light. Although it was not the scope of my study to measure the outcomes of the different alliance-forms, it is interesting to note that the effectiveness of the Recovery Model has been studied extensively. For instance, Warner (2010) carried out a review of published outcome studies and depicted the effectiveness of approaches based on the philosophy of the Recovery Model (p.5). In their 3-year follow up study about outcomes in schizophrenia, Lambert, Naber, Schacht, Wager, Hundemer and Karow (2008) provided further compelling evidence of the benefits of this model. In another study that may have important implications for my study, Tilsen and Nylund (2008) described how the effectiveness of the recovery model is strongly dependent on the therapeutic alliance (p.340). To this extent, they identified a meta-analysis by Wampold (2001) which showed that 54% of therapy variance was accounted for by the alliance (p.345). This led the authors to conclude that care providers must be flexible to care receivers' needs in a collaborative alliance in order to facilitate recovery. Interpretivist research such as that carried out by Dziopa & Ahern (2009) and Ackermann & Hilsenroth (2003) presented similar findings and suggestions in promoting the use of a recovery approach. Thus it seems as if the *Collaboration* alliance-type may be one that leads to positive care outcomes.

### **4.2.4 Conclusion**

The analysis and discussion of the service users' interviews led to the identification of the four main discursive themes that have been presented. A number of important findings have been portrayed. At the forefront lies the conclusion that discourse may be playing an important part in shaping specific alliances that featured in this study.



In this regard, the findings show that commonly, the way that the service users in the study spoke about and perceived the knowledge-power balance in different alliances may be related to the way that they act within the perimeters of the same alliance. Thus, for example, the *Dissatisfaction-Compliance* alliance may be negatively perceived by the service user as being characterised by a power differential in favour of the professional. This may then be related to service user anger and resistance. In contrast, the service user in a *Collaboration* alliance may be satisfied with the perceived balance of knowledge and power within the alliance. Consequently, this may be related to assertive behaviour and active involvement in care. In my view, the findings are a good practical example of the Foucault's explanation of discourse and its effects, which can be summarised as: "systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak" (Lessa, 2006, p.285). The findings that emerged from this part of the study may also show that service users come in all shapes and sizes and the knowledge-power balance in the alliance is not always necessarily unidirectional, rigid and in favour of the professional. On the basis of this finding, I concur with Zur (2009) who contended that the therapeutic alliance may not necessarily be characterised by a power differential and in fact, power may manifest both on the care receiver's side as well as on the care provider's side of the therapeutic alliance (p.160). Finally, the interviews with the service users provided a first-hand account of the experience of being in a psychiatric hospital and part of various therapeutic alliances. Some of the experiences recounted were pleasant and appealing such as those that featured the service users engaging in assertiveness discourse in the context of a *Collaborative* alliance. In contrast, other stories that were narrated were unsettling such as those characterised by compliance discourse in the *Dissatisfaction-Compliance* alliance or the anger that characterised the *Resentment-Opposition* alliance. Whilst this part of the study is felt to have generated important information, it is hoped that in combination with the findings that emerged from the professionals' written records, a more comprehensive view of the knowledge-power balance in the alliance can be attained.

## 4.3 Analysis and discussion of the medical and nursing records

### 4.3.1 Introduction

This section of the chapter is primarily concerned with an in-depth analysis and critical discussion of the medical and nursing records that were included in this study.

In a similar manner to the analysis of the interviews with the care receiver participants, the analysis of the medical and nursing records has been carried out as guided by the Foucauldian Discourse Analysis framework developed for the purpose of this study. In this section of the chapter, there are several references to the term ‘medical and nursing records’. In an attempt to enhance clarity, it serves to note that the term medical records refers to a file that holds reports written by doctors only whereas nursing reports are maintained by nursing staff only.

The first step followed during analysis was that of *Data Acquaintance*. During this process, certain trends or characteristics were immediately evident such as, for instance, the technical and minimalistic writing style noted in the majority of entries in the records. In particular, this feature guided me into longer periods of reflexivity since a void - that which is not written - may not necessarily facilitate and hasten the analysis process but may lead, as in this case, to deeper curiosity and speculation about the blanks as well as the written words. This is in line with Foucault’s perspective when he emphasised that rather than trying “to write the history of [the language of psychiatry]”, his interest lay in exploring “the archaeology of that silence” (Foucault, 1961/ 2001, p.xii).

The subsequent step was the process of general Thematic Analysis which led to the assignment of codes to data excerpts, as facilitated by the qualitative analysis software *Atlas.ti*. Following a process of reduction and refinement, a list of codes was compiled.

Following this primary analysis of the data, a more detailed exploration of the knowledge-power interface within the texts could be pursued. As guided by the third step in the Foucauldian Discourse Analysis framework used, the main discursive themes could then be identified. Three such themes emerged from the data and have been used to structure this section of the chapter.

In each of the three discursive themes that form this section, an introductory description of the theme is first provided followed by the discursive constructions of the therapeutic alliance as shaped by the dominant discourses within the theme (Step 4 of the Foucauldian Discourse Analysis framework). This leads into a deeper exploration by identification and analysis of the dominant discourses and the subject positions that they offer with the associated consequences for parties within these positions. Finally the effect of discourses on practice is ascribed to (Steps 5-8 of the Foucauldian Discourse Analysis framework).

Prior to delving into an exploration of each of these themes, an overview and presentation of the analysis shall be provided in order to depict a summative picture of the process and the final product.

## **4.3.2 Analysis of the medical and nursing records**

### **Introduction**

The first step of the analysis consisted of reading and re-reading the medical and nursing records that were included in the study. This was undertaken so that I could familiarise myself with the data and reflect upon the written words and their meaning.

### **Primary analysis: general thematic coding**

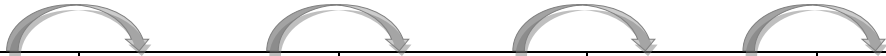
The subsequent step involved a process of inductive coding whereby descriptive codes were assigned to the data. This was carried out so as to organise the data into manageable chunks and allow for further detailed analysis. A worked example and a list of primary codes that resulted from the process of thematic coding are found in Appendix 4.

### **Secondary analysis: main discursive themes related to knowledge-power**

Following the primary analysis process, the coded medical and nursing records were reviewed again. At this stage, the aim was to identify main themes related to knowledge and power. This process led to the identification of three main discursive themes in relation to the knowledge-power interface within the therapeutic alliance.

Table 4 summarises the whole analysis process by showing the general codes that emerged from the primary analysis and how they were categorised into themes during secondary analysis. These themes were then further explored to identify the discursive constructions of the therapeutic alliances and the dominant discourses.

Table 4: The analysis process (medical and nursing records)



<b>Primary analysis: codes</b>	<b>Secondary analysis: main discursive themes</b>	<b>Discursive constructions (of the therapeutic alliance)</b>	<b>Dominant discourses</b>	<b>Subject positions</b>
<p>Medical terminology</p> <p>Automatic wording</p> <p>Custodial approach</p> <p>Authoritative terminology</p>	<p><b>A Pathological Lens</b></p> <p>Key features: <i>Use of the medical model as the sole explanatory framework</i></p> <p><i>The authority of the professional as the “gatekeeper” of the normal and the acceptable</i></p>	<p>A clinical package</p> <p>A series of professionally determined interactions</p> <p>A gauge of the care receiver’s readiness to behave and follow orders</p>	<p>Pathological Discourse</p> <p>Conservatist Discourse</p> <p>Authoritarian Discourse</p>	<p>Authority</p> <p>Safety/ self-protection</p> <p>Expertise</p>
<p>Task orientation</p> <p>Automatic wording</p> <p>Medical terminology</p>	<p><b>Depersonalisation</b></p> <p>Key feature: <i>Removing the person from the patient</i></p>	<p>One-way nonparticipant observation</p> <p>Task oriented</p>	<p>Minimalistic Discourse</p> <p>Depersonalising Discourse</p>	<p>Authority</p> <p>Ethical uniformity</p> <p>Safety/ self-protection</p>
<p>Patient involvement</p> <p>Patient-oriented approach</p> <p>Use of the patient’s actual name</p> <p>Use of the patient’s actual words</p>	<p><b>Humanism</b></p> <p>Key features: <i>Mutual involvement</i></p> <p><i>Collaboration</i></p>	<p>A medium for collaboration</p> <p>A method of mutual involvement</p> <p>Patient focused</p>	<p>Humanistic Discourse</p> <p>Equality Discourse</p> <p>Recovery Discourse</p>	<p>A holistic viewpoint</p> <p>Partial Knower</p> <p>Humbleness</p> <p>Partnership</p>

In the following pages, Figures 10 - 12 present a concise view of the three main discursive themes with their respective codes. A brief description of each of the three themes has been provided and a number of excerpts which describe each of the themes have also been included in each diagram.

**Figure 10: Theme 1 - A Pathological Lens**

**Description:**

This refers to discourse that is mainly dominated by the use of technical or pathological terms.

**Excerpt examples related to this theme – A Pathological Lens:**

*(Care receiver)* grandiose [MR2:E4]

Denies auditory or visual hallucinations [MR4:E2]

*(Care receiver)* not overly psychotic [MR5:E2]

*(Care receiver)* compliant to treatment [NR8:15]

Not clinically depressed [MR3:E1]

Calm and co-operative [MR3:E3]

When *(care receiver)* was confronted re stalking another patient, blames another woman. Attention seeking [NR6:11]

Level 1 supervision maintained by Nurse X. [NR1:4]

Took his treatment as prescribed [NR1:12]

Main garden leave permission – accompanied [MR1:E6]

## Figure 11: Theme 2 – Depersonalisation

### **Description:**

This features a way of referring to the therapeutic alliance in terms that tend to mechanicalise the interactions and the entities within it. As a direct consequence, it is felt that the person factor is being removed from the equation by excluding the specific qualities, experiences and other characteristics that contribute to the uniqueness of each individual.

### **Excerpt examples related to this theme - Depersonalisation:**

House chores done. Treatment given as prescribed. [NR5:2]

Patient found in ward. Treatment given and taken as per chart. Calm and co-operative. Slept. [NR9:18]

Day report: Level 1 not covered. Treatment refused am and pm. Comfortable day. [NR1:19]

Day report: Treatment given as prescribed. Level 1 converted to level 2 - covered by Nurse X. Passed a good day. Treatment refused throughout the day. [NR1:17]

Increased appetite. Feels irritable. Claims that she has been sleeping more. [MR7:E5]

Discussed with husband - he wishes to have patient home to support family. [NR6:4]

### Figure 12: Theme 3 – Humanism

#### Description:

This describes a professional's approach which, to an extent, places emphasis on the value of individuality, person involvement, personal meaning and holistic care.

#### Excerpt examples related to this theme - Humanism:

Plan: Patient agreed to above plan - leave for 1 week from today. To come next Wednesday evening and to sleep here. To give feedback on Thursday to firm. [NR6:4]

Claims that she has been having very bad days as well as days when she feels well but not elated. Patient complaining of lethargy. No change in appetite. Patient feels anxious over minor things and feels that she cannot open up with anyone even though she has a good relationship with her husband. [MR9:7-9]

Feedback psychologist: Would like to go back home although unsure. Talks about her husband, hurt that he threw away her things but then justified his actions and anger. When he brought her home, his friends were telling him: "Ghalfejn gibtha lura? Ghax ma hallejtix fejn kienet?" (*Why have you brought her back? Why didn't you leave her where she was?*) When she envisions her future going back home, she feels anxious. [MR5:E3]

#### Conclusion

Following the presentation of the analysis, the next section consists of a discussion related to the dominant discourses, subject positions and consequences of the discursive themes that emerged from the medical and nursing records that were included in the study.



### **4.3.3 Discussion of the medical and nursing records**

#### **Introduction**

Analysis of the data collected from the medical and nursing records has culminated in three discursive themes, namely:

- Theme 1: A Pathological Lens
- Theme 2: Depersonalisation
- Theme 3: Humanism

In this section, these discursive themes shall be discussed in the above order as guided by steps 4-8 of the Foucauldian Discourse Analysis framework that has been used.

For each theme, this involves an exploration of the theme, the constructions of the discursive object and the dominant discourses. Furthermore subject positions as well as the consequences of these positions on the subjects and on practice shall be examined.

#### **Theme 1: A Pathological Lens**

##### **Introduction**

This discursive theme involves text excerpts which were dominated by the use of technical or pathological terms. This medical manner of describing the interactions between the care provider and care receiver seems to be a popular approach in the majority of the nursing and medical records reviewed. Here, the alliance is constructed in various ways pertaining to the medical world. It has to be noted that the terminology that is being considered as being pathological/medical/psychiatric in nature, is not simply the type that is found in text books but also includes other terms or phrases that have found their way into the psychiatric system and may feature routinely in written records. Two leading examples of the latter in most of the

medical and nursing records in this study are: “(Care receiver) doing well” and “Treatment taken as prescribed”. This phenomenon, that I shall be referring to as *automatic wording* shall be explored at a later stage in this section.

## **Discussion**

Primarily, an exploration of the descriptions of the care receiver’s state by professionals whose texts were dominated by medical terminology shows references to the alliance by terms such as:

(Care receiver) slightly elated, overtalkative with paranoid ideation [MR2:E2]

(Care receiver) verbally aggressive; shouting ++ {MR1:E6]

(Care receiver) grandiose [MR2:E4]

(Care receiver) not overtly psychotic [MR5:E2]

In this way, the alliance is being constructed in terms of a clinical package characterised by an identified text-book symptom (or set of symptoms) associated with a particular diagnosis and standard ways of offering treatment or care in this regard. This seems to be the driving mechanism in the therapeutic alliance and that which governs the recovery process.

The description of the care receiver’s progress is also a powerful ingredient in the view of the alliance in pathological terms. In this instance, the care receiver was described as being:

(Care receiver) compliant to treatment [NR8:15]

Calm and co-operative [MR3:E3]

Feedback from nurse this morning: (care receiver) threw a battle since she wasn’t given attention [MR7:E5]

Here it feels as if the alliance is based and gauged upon the care receiver's readiness to behave and follow orders from the professionals. The care receiver's actions were also enmeshed within medical references where, for instance:

*(Care receiver)* proceeded on leave [NR6:12]

Patient went out on day leave under father's responsibility and as advised by Medical Officer [NR1:1]

When patient was confronted re stalking another patient, blames another woman. Attention seeking [NR6:11]

This may imply a construction of the alliance as a series of interactions where most of the care receiver's actions, or at least the ones that have been documented, are professionally determined and described in medical or technical terms.

The treatment/care description was particularly deeply ingrained in psychiatric language by references such as:

Level 1 supervision maintained by Nurse X [NR1:E4]

Main garden leave permission – accompanied [MR1:E6]

Took his treatment as prescribed [NR1:12]

Treatment given as per chart [NR2:10]

May be transferred back to Rehabilitation Unit [MR6:E2]

Similar to the previous constructions identified, it is here being indicated that the alliance is predominantly based upon a set of clear clinical instructions that need to be implemented if the alliance is to have therapeutic outcomes.

The feedback given by the care receivers as documented by this group of professionals is also shaped by medical terminology such as:

Denying auditory or visual hallucinations [MR4:E2]

Not clinically depressed [MR3:E1]

Moreover, in another instance, the feedback provided by the care receiver led the nurse to write that:

*(The care receiver has) good insight – willing to accept treatment [MR9:51]*

The same clinical reconstruction is applied to feedback from the care receivers' significant others where, for instance, one care receiver's parents were reported to have said that:

*(The care receiver) was verbally aggressive; shouting ++, threatening ++ [MR1:E6]*

A husband was also reported as having described his wife as being:

*Agitated at home..depressed, crying ...no paranoia [MR6:E1]*

A general look at feedback from the care receivers and their significant others as encountered in the written texts, may be portraying an alliance that does endeavour to take feedback into consideration - this feedback is then medically reconstructed and used as an evaluation of the medical care plan and the alliance. In this manner, the alliance seems to resemble a medical trampoline that serves as the base of various entities whose feedback undergoes a medical metamorphosis and is then used to shape the alliance and care.

Upon reflection on these multiple constructions of the alliance, it can be noted that the primary dominant discourse that governs this particular writing manner is **pathological discourse**. As already alluded to, this is evidenced through the use of clinical or psychiatric terminology to an extent that in certain cases, it is almost exclusively the sole way of writing about interactions within the alliance. The medical and nursing reports of Care Receiver 2 may be referred to as exemplars of this (Refer to the medical/ nursing records related to Care Receiver 2 on the DVD).

On reflection, it can be recognized that the rigid use of impersonal and clinical wording may be partly attributed to a traditional psychiatric (medical) model which places care receiver insight and decision-making capacity at the forefront of the clinical picture and the care plan. In one of his lectures about psychiatric power,

Foucault (1973/2008) discussed how the birth of the asylum led to the formation of “a certain type of discourse of truth” (p.93). The pathological discourse that I have encountered in my study may be a reflection of this discourse identified by Foucault where the truth is seen to lie within a pathological understanding. Subsequently this ‘truth’ - this pathological explanation - may dictate what the care receiver needs and what s/he is capable and incapable of doing. In fact, as an adjunct to the primary discourse-type, **conservatist discourse** occasionally weaves its way into the written words of the professionals. This is exhibited through the use of certain terms and phrases that are rooted in traditional psychiatry and may hold echoes of the somewhat morbid, coercive and custodial history that dominates this medical field. This is the type of psychiatry that Szasz (2000) often spoke about and perceived as being coercive in nature due to its tendency to limit the individual’s freedom. It is the “regime” identified by Foucault (1974/2008) - a constraining force that subjugates the care receiver - it may have changed its shape but it is in fact conservative in nature and still clings to the eighteenth century philosophy of disciplining the ‘mad’ (p.179). For instance, this type of discourse can be seen when one of the professionals in my study described the care receiver’s care plan as consisting of:

Permission for main garden accompanied only. To arrange to transfer his belongings to hospital or to his house. No permission to go out. [MR4:E3]

Another professional’s summary of his interaction with the care receiver concluded that:

Patient can continue same treatment and can go to mass and main garden accompanied. [NR4:16]

At one point, Care Receiver 9 was:

Granted leave under full responsibility of her husband. [NR9:19]

Similarly, in another report about the alliance with Care Receiver 8, the professional justified the withholding of information by stating that:

This information (*about the care receiver’s potential discharge from hospital*) was not given to her not to give her false hopes. [NR8:24]

A first glance at this latter excerpt possibly indicates a kind and caring professional who in his/her goodness, is attempting to protect the care receiver from disappointment. Still, I wonder, *how therapeutic can an alliance be if it is mainly being used as a baby cot - a safe haven that keeps out the dangers and disappointments of life?* Perhaps if this were a care receiver in the acute phase of mental illness, such a protective approach may be beneficial. However, here it has to be noted that the care receiver in question is at the end stage of rehabilitation – implying that soon enough this person may be potentially facing far bigger disappointments and change of plans, as part of real life in society. Foucault (1961/2001) alluded to a similar observation when he noted that when asylums were created, they attempted to transform the patients into children who needed to be protected and educated: “Madness is childhood...they are regarded as ‘children who have an overabundance of strength and make dangerous use of it’ ” (p.239).

Bracken and Thomas (1999b) also identified this phenomenon by referring to paternalism which may be guised under the ethical concept of beneficence (p.328). Interestingly, the authors referred to the Hippocratic Oath which binds healthcare professionals into making decisions in the care receiver’s best interest during medical practice. However, as the authors explained, keeping information from a care receiver or excluding him/her from decision making, under the mask of the beneficence, leads to a contradiction of this ethical concept. The same conservatist discourse featured in one of the professionals’ written reaction to a care receiver who was refusing injectable treatment:

Dr.X contacted and informed that the patient is refusing to take depot. Dr.X will contact Dr.Y for further instructions. If not successful, to postpone till Monday. [NR4:37]

It is interesting to note that the care receiver who features in this excerpt is one whose therapeutic alliance with his psychiatrist was a *Resentment-Opposition* type and so characterised by anger and resistance to care. Thus this may tentatively suggest that viewing the care receiver through a pathological lens may have a detrimental effect on the alliance by resulting in care receiver emotions that may hinder recovery. On encountering the above excerpts, I cannot help but ponder on a latent but very

powerful type of discourse that accompanies such texts – this is **authoritarian discourse**. Let us explore this by reflecting upon the direct or implied reference to ‘permission’, which featured commonly in the records encountered – a concept that may be connoted to a conservatist view of psychiatry where the professional holds the key to the care receiver’s very existence by controlling his/her actions in life. This is perhaps particularly evident in the latter excerpt included, whereas the professional who is writing the report contacted Dr.X who in turn intended to contact Dr.Y in order to get instructions on how to manage this care receiver who was refusing treatment. The question that springs to my mind is: *Where is care receiver’s voice in this seemingly medical monopoly?* Surprisingly, the answer to this question was partly presented to me during my interview with the care receiver who was being discussed in this latter excerpt (Care Receiver 4). Following the recording of the interview, this particular care receiver gave me a letter which he had written and insisted that I include it in my thesis (Refer to Figure 13). He went on to explain how during the ward round with the multidisciplinary team, he often feels confused and forgets that which he had intended to discuss. In order to address this, he had once decided to write a letter about his feelings related to medication side-effects and hence his adamant refusal of medication. He had then planned to discuss this letter in the professionals presence during the weekly ward round.

Medication (Tranquillisers)

Every drug is dangerous to the brain. The effects are both beneficial and detrimental. Psychiatric treatment that involves the use of drugs takes quite some time to start having beneficial effects and effectiveness is not guaranteed.

Drugs like tranquillisers affect the human body by decreasing its immunity, altering its pain response pathway and much more.

They are a nuisance to concentration ability, can turn sexual experiences into scary and failed adventures, may lead to blurred vision and much more.

Thank you, Patient.

Figure 13: A care receiver’s letter

It is a pity that this letter never made its way into the ward round. The care receiver explained that this was due to the fact that before the ward round, he had showed this letter to a nurse - the reaction of the nurse had been to mock him whilst informing him that the letter was full of grammatical mistakes. This disheartened and demotivated the care receiver who then decided to simply resume his loud and aggressive resistance to treatment. Here the point is not to portray an angelic care receiver and a demonic professional. Indeed, the real version of events remains a mystery in the confines of this retrospective one-sided narrative. Still, irrelevant of the true sequence of events, the product is an angry care receiver who is resisting treatment and who doubts whether the feelings that he has written down are good enough to merit inclusion in the ward round. In turn, I question: *Does professional status automatically appoint one as a gatekeeper who allows good information to enter the alliance whilst closing the gates to bad information? And if so, what determines the criteria for information to be classified as good or bad?* Perhaps it is the writing manner, the use of language that serves as one of the criteria, as implied in the case of the care receiver's letter that has just been described. Perhaps in this same case, another criterion may have been the possible inaccuracy or political incorrectness of the care receiver's words. Still, it is worthwhile to acknowledge that as accurate or inaccurate as the care receiver's perception may have been, this was his understanding of the situation and therefore as real to him as its inaccuracy may be to others. Rogers (1961) placed particular emphasis on this when he stated that "It is the client who knows what hurts, what directions to go, what problems are crucial" (p.12). Once again, I refer to Bracken and Thomas (1999b) who elaborated on the concept of medical paternalism which assumes that treatment can only be based on medical decisions and not on the person's beliefs and personal preferences. This leads to an infringement of the care receiver's autonomy (p.238). The notion of a gatekeeper or "arbiter" was also mentioned by Goodley (2001) when he explored the social model of learning disabilities (p.210). He suggested that it is society itself that may be creating disabilities and acting as a gatekeeper to understandings of bodies and minds that differ from 'normality'. Goodley (2011) elaborated on this by describing how one of the consequences of this type of social model is that the person may be seen in terms of "deficit" – 'an organic impairment of intellectual functioning, social incompetence and maladaptive functioning' " (p.31).



A closer look at these three discourse-types reveals discursive positions that seem to be hosting a rather clinical and sometimes ‘cold’ set of perceptions and attitudes. One may wonder: *what are the subjective feelings of the professionals in these positions and what is the rationale beneath such a demeanour?*

Perhaps the most obvious contention in this case is that here we are being presented with a care giver whose professional existence is rooted in the medical model and in traditional ways of authoritarian psychiatric practice. This may be brought about by various factors, such as the professional’s learned ways of practice – inherited clinical practice that passes from one generation to another:

The clinic is basically a staged presentation of the patient in which questioning the patient serves the purpose of instructing students, and in which the doctor operates on the double register of someone who examines the patient and someone who teaches the students, so that he will be both the person who cares and the person who possesses the master’s word (Foucault, 1974/2008, p.185).

In the care receivers’ interviews, the sense of professional authority was discussed by many of the participants. In excerpts such as the ones that have been presented in this theme, the authoritarian attitude may similarly be seen as being present in the writing of some of the professionals. Perhaps then it would help to bring the cultural aspect into focus once again in order to understand the driving mechanism behind this attitude. This study is taking place on an island where professional status has traditionally been attributed immense importance and power, not only in professional practice but also in everyday decisions in society – this is in practice till this very day. Thus, the act of successfully completing tertiary education may serve to give one a sense of authority in society. This is especially true for some disciplines, in particular the medical and legal fields. It is likely that this may be one of the influential issues on the power balance in relationships such as the ones being explored in this study.

Alternatively the professional may be using his/her professional knowledge and clinical terminology as a shield within therapeutic alliances which may be undeniably challenging to be part of. Here I am contending that the professional

knows that s/he shares one very important characteristic with the care receiver: the human nature. This realisation may reveal the somewhat scary truth that in reality, the difference between the care receiver and the professional is not so vast. Hence, the professional may be prone to develop the same symptoms that s/he is attempting to cure and thus become a care receiver. In *Madness and Civilisation*, Foucault (1961/2001) made references to this challenge – this macabre aura that may characterise the therapeutic alliance: “The substitution of the theme of madness for that of death does not mark a break, but rather a torsion within the same anxiety. What is in question is still the nothingness of existence” (p.13).

Similarly, Laing (1960) suggested that there is no difference between the psychiatrist and the psychiatric care receiver – any visible gap has been brought about by the psychiatrist’s professional training which promotes the alienation of the care receiver (p.33). In this light, the promotion of a clinical and professional front may make sense since it affords the professional the luxury of an arms-length distance between himself/herself and the care receiver within the alliance. It is an attempt to distinguish *us* (the healthy) from *them* (the sick) and a reassurance that after all *we* are not so familiar to *them* and so we are safe from mental illness. It is also a distance that may keep over-familiarity and undesirable care receiver behaviour at bay and indeed, a powerful piece of equipment in managing difficult situations. Thus, the cover of academic knowledge and the authority provided by the professional status may very well serve as a safe haven in stormy waters.

Moreover, adherence to the main contentions of the traditional psychiatric medical model may place the professional as the all-knowing entity who needs to hold the power lead in the alliance and to maintain continuity of the same form of practice:

Take the notion of tradition: it is intended to give a special temporal status to a group of phenomena that are both successive and identical (or at least similar); it makes it possible to rethink the dispersion of history in the form of the same (Foucault, 1972, p.21).

This may not only serve to fuel the professional’s superior power but can also provide the reassurance that may be required when working in mental health – a

field that is cluttered with incomplete evidence, debatable areas and unclear treatment paths especially in comparison to other medical specialties which are more highly evidence-based (Szasz, 1970, p.23). In the same token, the pathological discourse may then offer the professional a position where s/he can comfortably explain the care receiver's undesirable (and perhaps somewhat mysterious) behaviour by superior scientific knowledge and diagnostic systems. Foucault (1961/2001) regarded this position as being extremely powerful as the professional figure is surrounded by an aura that verges on the supernatural – the entity who can provide explanations and has quasi-miraculous powers (p.261). In turn, this places him/her in a position of authority and confidence where s/he can manage the undesirable behaviour and treat the care receiver as required, on the basis of time-tested traditional ways. However Foucault (1972) was cautious about this type of practice:

We must question those ready-made syntheses, those groupings that we normally accept before any examination, those links whose validity is recognized from the outset; we must oust those forms and obscure forces by which we usually link the discourse of one man with that of another; they must be driven out from the darkness in which they reign (p.22).

The authoritarian position that may result from pathological discourse may be limited to the few and may be quite defined with set characteristics and rigid inclusion/exclusion criteria – for instance, for inclusion within this elite niche, it seems as if one has to be able to understand psychiatric language (medical jargon). Interestingly, some of the care receivers interviewed in this study hinted at the fact that professionals have a specific way of speaking/writing that may not be so easy to understand by those who are outside the profession. In particular, Care Receiver 3 commented:

I think that professionals have a language of their own. In that, if they want to say something about us in front of us, they know how to get around it. By saying certain words in another way, in the same language. [CR3:27]

Similarly, Care Receiver 6 referred to this phenomenon by stating that:

I do not understand the language of the professionals - their language is too complex. Sometimes it is in Maltese and sometimes it is in English. But it is

complex. Words that I do not understand. Oftentimes, the consultant psychiatrist asks me if I have understood. And I reply: “As if I can understand what you have been saying!” He gets angry then. [CR6:21]

At times, the consequence of the use of this exclusive psychiatric language may be directly detrimental to the care receiver involved as it may serve to widen the power gap between the two entities in the alliance. This may be evident in the following narration by Care Receiver 2 which outlines a care provider attitude that may confuse the care receiver. In this excerpt, the care receiver was discussing Serenace - this is a drug that is especially used in the treatment of psychosis. However, it seems as if due to incomplete/inaccurate information that may have been given by the doctor, the care receiver believed that he is taking this drug to enhance his singing voice:

I do not understand some of the words. I do not understand the names of pills but I understand the rest. Serenace is a treatment used for the voice...that is what the doctor said. He said: “It is ‘Serenace’ by Claudio Villa!” The song ‘Serenata’ by the singer Claudio Villa. He did not give me any other information so I assumed that it is used for the voice. And so I started to sing during the ward round. [CR2:22]

Here I seek to reiterate that this critique and my position in it, is not an anti-psychiatry endeavour – my intention is not to disparage scientific evidence, diagnostic systems and care management pathways that are used in psychiatry. On the contrary, I believe that these are tools which may be incorporated within the therapeutic alliance and used as possible explanations or guides that may help some of the individuals seeking help. However, regarding these tools as the definite and only explanation, such as, for instance, referring to diagnostic systems like the DSM as the psychiatric bible (Jabr, 2012, p.1), is felt to be a claim to absolute certainty which may be detrimental to the therapeutic alliance: “Formerly, when religion was strong and science weak, men mistook magic for medicine; now when science is strong and religion weak, men mistake medicine for magic” (Szasz, 1973, p.115). Primarily, this is because the use of the authoritarian voice, as exemplified by some of the texts encountered, is felt to be potentially oppressive to care receivers who may then be automatically considered as being less knowledgeable and less powerful within the alliance. As seen from the analysis of the care receivers’ interviews, this

may lead to alliances characterised by power imbalances and care receiver dissatisfaction, such as the *Resentment-Opposition* type. Although the scope of this study was not to measure therapeutic outcomes linked with particular alliance-types, reference can be made to numerous studies that sought to address the association between care provider characteristics and therapeutic outcomes. It is not surprising to note that studies, such as those by Dziopa & Ahern (2009) and Ackerman & Hilsenroth (2003) almost invariably concluded that certain characteristics like promoting equality, giving options and using ordinary talk tend to enhance therapeutic outcomes - these very characteristics may be lacking in the *Resentment-Opposition* alliance-type in particular.

Secondly, it has to be acknowledged that as vast as a professional's clinical and academic knowledge may be, the act of writing a report about a care receiver's features such as his/her state or progress, is mostly a representation or an understanding of the presenting features unless the professional writes down the exact words uttered by the care receiver. This implies that some content of medical and nursing records, including most of those that feature in this study, are a secondary source of information – a set of objective observations within the alliance (Merleau-Ponty, 1945/1962, p.188). In this case, there may be a discrepancy between the understood and reconstructed version of events by the professional and the care receiver's subjective communicated experience (Bertram and Stickley, 2005, p.389). This may be exemplified by an excerpt taken from one of the nursing reports:

Ward round with Dr.X. Discussed due patient attention-seeking behaviour - when she does not have attention, pain of fibromyalgia seems to increase.  
[NR6:4]

In this example, the use of the phrase “attention seeking behaviour” refers to a professional's interpretation and assumption. On reflection, the only certainty in this case is the fact that at times, the pain of fibromyalgia seems to increase and that one association may be the fact that the care receiver needs attention. The difference lies in interpreting and presenting a situation as a dead sure fact - “attention seeking behaviour” - instead of postulating tentative explanations about causality and associations. The use of this type of wording is even more worrying when I realise

that locally, terms such as “attention-seeking behaviour” are connoted to a meaning that goes far beyond the direct implication of the words themselves. This is because this term commonly conjures an image of a problematic care receiver who is a nuisance to staff members due to his/her constant nagging and manipulative attempts. Perhaps then it is not surprising that the care receiver who features in the above excerpt was one who had a *Resentment-Opposition* therapeutic alliance with the nurses. During my interview with this care receiver, I was particularly struck by the strong wording that she used when describing her interactions with the nurses, going as far as to describe their [the nurses’] behaviour as ‘savage like’. Hence, I feel that caution must be exercised in the use of automatic heavy terms such as ‘attention seeking’ because they involve the application of a label to the care receiver in question and may contribute towards a power imbalance that irritates and frustrates the care receiver.

I feel that this is additionally dangerous because if the reconstructed understanding is then used to guide treatment, then the effectiveness of such treatment may be limited from the very beginning. Once again, this reminds me of Szasz’s television analogy in his insistence that a television engineer (a professional with a medical understanding of mental illness) cannot address problems such as viewers disliking a particular programme (an individual with a different understanding of symptoms) (Szasz, 2007, p.6). Perhaps the application of critical realism may be beneficial in this situation in that the main contention in this movement holds that “all theories of the world are seen as grounded in a particular perspective and worldview, and all knowledge is partial, incomplete and fallible” (Maxwell, 2012, p.5). I feel that this questions the use of authority in writing about or planning care on the care receiver’s behalf without considering the care receiver’s perspective.

In some of the medical records, especially in the majority of the nursing reports, automatic wording seems to form an intricate mesh with pathological, authoritarian and conservatist discourse-types. Automatic wording refers to what has been earlier described as those terms that have found their way into the psychiatric system and tend to feature routinely and at times, aggressively in written records. In the written

records, this trend commonly featured as a chain of medical terminology that seemed strikingly cold and tended to de-humanise the care receiver:

House chores done. Treatment given as prescribed. No complaints. [NR5:4]

Perhaps at a first glance, such automatic wording may not seem particularly ill-fitting within the alliance between a care provider and a care receiver. However, this viewpoint may change on realising that each of these examples was often the one and only statement that described a whole day in a care receiver's life. Moreover, in some cases, such as in the nursing report of Care Receiver 4, these same standalone statements were repeated day after day such that the only information communicated about a 7-day span in a care receiver's life inside the hospital was that he had had comfortable days and nights. It is notable then to realise that both Care Receivers 4 and 5 were ones who, during the interviews, spoke so much about what goes on in their daily life. For instance, Care Receiver 4 made a particular effort to delineate what he wants his life to be like and so described wishes and dreams that he would like to actualise. Similarly, Care Receiver 5 spoke about the deep thoughts that she has in relation to her current quality of life and the effect of her mental distress. To me, this is so different to the flat and eventless manner that these individuals' existence is being recorded in the records. As a mental health professional and as a Maltese person who may one day be subjected to the need of state psychiatric care and possibly this type of descriptions, I have to confess that I feel vulnerable and hurt. My question is: *How can you reduce a person's seven-day existence, with all the thoughts, feelings and actions that inevitably characterise each passing moment to such simplistic statements such as the ones encountered?*

This, to me, resembles the act of pigeon-holing – fitting care receivers inside pre-constructed slots which may result in the stripping of the care receiver's identity as a human being and reduce him/her to a text-book diagnosis. This act of depersonalisation shall be further elaborated on in the subsequent theme.

## **Conclusion**

A possible implication of these discourses on practice is that in the same instance as providing the professional with the claim to superior knowledge and power, it may simultaneously place the care receiver in a vulnerable position. One may wonder then if such medical dominance may potentially serve as a catalyst for coercive practice, in particular, 21<sup>st</sup> century covert actions such as the neglect of care receiver rights, overprescription of psychiatric drugs and non-action/ reinforcing actions in light of a care receiver's passive attitude (Szasz, 1970, p.xxvii). On referring to these undesirable actions, a care giver's custodial and patronising attitude is also here being considered as falling within the remit of such coercive practice. This may be exemplified through written phrases such as "Patient wants to have things her way" [MR6:E4] – a standalone statement found in one of the professionals' records with no accompanying proof or description of how this judgement was made. Thus, through this lens, the care receiver may be viewed as not possessing valuable knowledge and is expected to practice submissiveness to the psychiatric discipline with an image of the world in pathological terms. This viewpoint connotes potential losses, especially for the care receiver who may have to compromise his/her independence and autonomy. In fact this was verbalised by this same care receiver who narrated how she feels that some professionals, especially nurses, do not treat patients with respect by shutting them out and treating them as inferior. Alternatively the pathological, authoritarian and conservatist discourses may hold special appeal for a care receiver whose perception of the professional alliances that s/he is part of, is ingrained in traditional and hierarchical discourse, such as commonly seen in the *Satisfaction-Acceptance* alliance type. In this regard, pathology and conservatism may offer the care receiver a position of safety – a constant, predictable and rigid ledge in the steep cliff that may characterise the experience of mental illness.

## **Theme 2: Depersonalisation - an alliance with a non-person**

### **Introduction**

A particular discourse-type that was evident in some of the texts written by professionals contributed to the emergence of the discursive theme of



depersonalisation. This features a way of referring to the therapeutic alliance in terms that tend to mechanicalise the interactions and the entities within it. As a direct consequence, it is felt that the person factor is being removed from the equation by excluding the specific qualities, experiences and other characteristics that contribute to the uniqueness of each individual. This manner of describing the interactions between the care provider and care receiver seems to be particularly common in the majority of the nursing records reviewed whilst still featuring frequently but to a lower extent in the medical files.

## **Discussion**

On looking at this way of writing, a vivid image of the construction of the alliance within this discursive theme came to my mind. Here I was viewing a one-way observation of the care receiver by a professional who is seemingly situated at a distance, peering through binoculars. This distant tone may be felt through standalone statements that describe the care receiver's state, actions or progress such as:

House chores done. Treatment given as prescribed. [NR5:2]

Patient found in ward. Treatment given and taken as per chart. Calm and co-operative. Slept. [NR9:18]

Joking inappropriately, Grandiose. [MR2:E4]

Night report: Stated that feels tired. Treatment given. [NR5:5]

Simultaneously, it feels as if in this theme, the alliance is being constructed as a non-participant observational activity where the professional is there mainly as a figure of authority - a spoke in the wheel that is the health care system. This complements the construction of the alliance described in the previous paragraph: the combination of the two suggests minimal involvement from the side of the professional apart from the basic activities that need to keep the system going. As a particular example, one nurse's day report about Care Receiver 1 consisted of:

Day report: Level 1 not covered. Treatment refused am and pm. Comfortable day. [NR1:19]

Similarly, another nurse wrote about her observations of the day activities carried out by Care Receiver 5:

Day report: House chores done. Treatment given as prescribed. No complaints. [NR5:4]

Finally, it may be noted that in this instance, a task-oriented construction of the alliance is also in action. This refers to interventions, actions and interactions that are addressed as a task rather than as a part of an alliance that aims at celebrating and exploiting the individual qualities for therapeutic purposes. For instance, during one particular day, Care Receiver 6 is described as having:

Attended to own personal hygiene. 7am and 2pm doses given as per chart. Rantudil Forte given at 9am as patient complaining of pain. Visited by husband this am. [NR6:20]

Another nursing report, this time about Care Receiver 7, is also felt to indicate the focus on task orientation:

She complained of stomach pains - Gaviscon given. Blood pressure checked 120/80. No more complaints. Went on leave till next Thursday. Treatment given till Thursday morning. [NR7:9]

The discursive constructions that have been described lead to the identification of two main discourse types, these being **minimalistic discourse** and **depersonalising discourse**.

Minimalistic discourse may be described as a simple and abrupt way of reference. In writing, this features as short, bullet-like sentences that attempt to convey information about a particular state, action or plan. In the medical records that are characterized by this discourse-type, these statements mainly concern a brief, minimalistic summary of the care receiver's symptoms, progress and treatment plan. When minimalistic discourse features in the nursing records, the information conveyed is even briefer and mostly consists of descriptions of less than ten words that commonly cover a 12-hour span in the care receiver's life at the psychiatric hospital. This discourse-type is located within the wider discourse of depersonalisation - in this study, this is being understood as referring to the act of

removing the person out of the care receiver: a process that can be likened to the coring of the pulp of the person and then mechanically dealing with the outer shell that remains. Depersonalising discourse is particularly evident in those medical and nursing records that are especially characterized by Pathological Discourse (described in the previous theme) and Minimalistic discourse.

As the two dominant discourses in this theme, minimalistic and depersonalising discourse give rise to a number of subject positions and consequences in practice. As a starting point to the exploration of minimalistic discourse and its discursive positions, I am first going to reflect upon the purpose of medical/ nursing records without attempting to reflect upon knowledge-power issues. This is going to be done by side-stepping into the field of nursing education and practice, which is my area of origin, where according to Berman and Snyder (2007, p.252), the main purposes of documentation are for:

**Care Planning:** Health professionals use data generated from other professionals' reports in order to evaluate care and formulate/ modify care plans.

**Communication:** Due to the obvious inability of all health professionals to be present in the clinical area at all times, written records may be a good way of communicating events in one's physical absence. Written words may also serve as a reminder/ diary of actions and events.

**Legal situations:** Records are admissible in court as evidence.

**Research and Statistics:** This study is a primary example of written records being used for research purposes. Moreover statistical data can be extracted from records in order to inform wider endeavours such as health care service planning on a national agenda.

**Education:** Once again, using the nursing discipline as an example, students have placements within the clinical area and are encouraged to review records in order to

understand the skill of record writing as well as to gain a more comprehensive understanding of the care receiver's recovery journey.

**Quality Assurance:** Documented care can be used to measure the quality of care delivered and the competence of the care provider as measured against established standards.

On comparing the above purposes and the minimalistic discourse encountered within the records encountered, I conclude that it is very hard to say that any of the above goals are being met by the majority of records, especially the nursing reports, included in this study. This is the point where perhaps this discussion may bear resemblance to a clinical appraisal. Whilst the main aim of this thesis was to explore the knowledge-power interface within the therapeutic alliance, I feel that the data collected also needs to be viewed against the backdrop of the overall quality of care that is being offered. This is especially important in the understanding of the implications of my study as well as to offer recommendations on the basis of my research.

Prior to delving into a deeper discussion, it is felt that an initial consideration that needs to be made is that here we are preoccupied with medical/nursing-report writing and not the writing of a book that may allow one to write at length and to make use of his/her artistic license. Hence, it is understandable and in fact, widely recommended that medical and nursing reports need to be concise in order to convey only that information which is relevant to care in a timely manner (The Ministry of Health and Te Ao Maramatanga, 2012, p.266). This may partly explain the brevity of the entries in medical and nursing files. In this manner, the care provider's position is that of a professional who is acting upon learned ways of practice and who is indulging in minimalistic discourse due to its perceived professionalism, appropriateness and effectiveness. However, on reflecting on this writing style, it needs to be acknowledged that there is a clear distinction between the meaning and desirability of the terms *conciseness* and *brevity*. Whereas conciseness involves the act of providing the necessary information in a clear and comprehensive manner, brevity simply refers to writing in short with the possibility of omitting important

data. The majority of records encountered during the study, especially the majority of nursing reports, are felt to be more characterised by the latter rather than the former. A brief reflective exercise upon the following ward round report from one of the medical files may highlight this point:

Ward round with Consultant psychiatrist:  
Patient is doing well at rehabilitation unit  
Not psychotic  
Low mood  
Patient wants to have things her way  
Plan: Keep patient at rehab unit for now  
Continue same treatment  
To be seen by a rheumatologist [MR6:E4]

On reading these words written by the professional, I ask myself whether I am confident about my knowledge of what actually happened during this particular ward round. My answer is clearly negative since many questions about this event remain unanswered such as:

- *What is meant by 'doing well'? What kind of progress has been observed?*
- *What is the nature of the 'low mood'? What is the care receiver's subjective experience?*
- *How, why and in which context does the care receiver want to 'have things her way?'*
- *Why is a rheumatologist needed?*

Moreover, the care receiver who is being described in this medical report is one who insisted that she feels disadvantaged in the psychiatric setting since she feels that she lacks power especially in the presence of nurses. She described how at times she feels disrespected and how once she had trusted a professional with her secrets who had then disclosed this information to others without the patient's consent. Thus it may not be a wonder that this patient wants to 'have things her way' – however such a minimalistic statement without further explanation leaves much to question and makes me wonder about why such issues, which may be hindering this care receiver's therapeutic alliances, do not feature in this record. Here, the problem lies in the fact that in addition to the recommendation for records to be concise,

educational and clinical stakeholders tend to advocate for completeness and accuracy (Dziopa & Ahern, 2009, para.4; Berman & Snyder, 2007, p.266). When viewed against this backdrop, a number of clinical concerns become visible in relation to the majority of records located in this study. Primarily, one has to attempt to identify the general documentation style in use as this may help to gain understanding of what the health care professionals in this study are intending to communicate. On reverting once again to literature on medical/nursing documentation, it can be noted that there are several taught and practiced ways of professional documentation in health care. Once an institution adopts a particular style, then it commonly adapts it for use in that specific culture. Berman and Snyder (2007, p.256) described the general types of charting cited in the literature:

**Source charting** (such as narrative charting) – this includes a separate section in the file for each discipline and in the case of narrative charting, documentation includes routine care and care receiver problems. The order of information is usually chronological. This charting style is not prominently used in contemporary health care.

**Problem-oriented medical charting** – in this method, data are arranged according to care receiver problems with different disciplines and professionals contributing to the problem list, care and progress notes.

**Focus charting** places the care receiver and his/her concerns and strengths as the focus of care. The focus in a particular report may be a condition, a diagnosis, a behavior, a sign or symptom, a status change or a care receiver strength.

**Charting by exception** involves the documentation of exceptions or abnormalities only.

On attempting to match the general documentation-style of the records located to the ones cited in the literature, the task proves to be difficult. Perhaps the closest resemblance would be to narrative charting but one that is here characterised by brevity and lack of order. It is felt that this is a barrier to reaching any of the six

documentation purposes identified earlier. Allowing myself another look at these documentation purposes, I feel that it is a matter of major concern that such minimalistic documentation may then be the local driving force of care evaluation and planning, communication about the care receiver's recovery journey and quality assurance. Furthermore, this proves a challenge to education since as stated earlier, healthcare students are encouraged to seek these records. The knowledge that these records may also need to be used in legal situations poses another risk that can be associated to numerous negative consequences particularly for the professional.

Still, the emphasis in this thesis is the therapeutic alliance and so at this point, it may serve to slightly re-shift the focus and explore the link of the minimalistic discourse to the alliance and its implications on it. Primarily, it has to be acknowledged that this writing style may or may not reflect the professional's actual behaviour within the alliance because the professional may be restricting the use of this minimalism solely to record-writing and not to the actual practical interaction with the care receiver. Therefore, it would be erroneous to automatically assume that the professionals' minimalistic documentation style necessarily reflects the nature of the therapeutic alliance or the knowledge-power interface within it. However, let us momentarily borrow an important statement that commonly features as one of the basic principles of health care management. This simply reads as: "Not written, not done" (Morrissey-Ross, 1988, p.363). Here one can indulge in a debate about the extent of information that written words can convey in their attempted reflection of practice. Indeed, it has to be acknowledged that documentation often does not do total justice for the totality of practice carried out. However, at least it should attempt to capture a good part of the practical experience and to describe it in a realistic manner (Parkinson & Brooker, 2004, p.46). On applying this management principle to some of the medical/nursing records located, another major concern is identified, particularly by looking at the chain of nursing reports related to eight out of the ten care receivers included in the study (nursing reports pertaining to Care Receivers 6 and 9 being the exceptions). On excluding the plethora of automatic wording (described in Theme 1) that clutters these reports, one may attempt to identify information about the therapeutic alliance and activities/ interactions that reflect the

formation and maintenance of this alliance. It is disheartening to realize that the only therapeutic activities written as being done are exclusively:

Treatment given/ Treatment given as prescribed/ Treatment given as per chart/ Depot injection given and charted [NR5:22] [NR8:22] [NR4:1] [NR2:36] [NR3:8]

Level 1 supervision maintained [NR1:31]

Referral for rehabilitation done [NR1:10]

Blood pressure checked [NR7:9]

Here it has to be noted that each entry in the nursing report may be written by a different nurse and so this documentation-style does not appear to be simply attributed to just one nurse but may be widespread across different nurses and settings within the hospital. It is felt that the above finding is a prime reflection of custodial and defensive care that is aimed at addressing the basic medical care and protecting the day-to-day running of the ward and the psychiatric system. If this was a study concerning a general medical hospital, the above documented care would probably still be considered as being minimalistic. However, it is even more alarming to realise that this is a psychiatric setting – a discipline that is expected to dedicate intense focus on the individual's thoughts, feelings, behaviour and perceptions with routine medical tasks such as the ones seen in the excerpts, occupying a second place. With reference to some of the professionals whose texts were included in the study, especially the nurses, it is quite inevitable to follow this reflection by questions such as:

- *What kind of therapeutic interventions are actually being carried out?*
- *What is being done within the alliance to promote recovery and reach therapeutic outcomes?*
- *Is the therapeutic alliance being considered as an important platform that roots all interventions or is it simply an accidental alliance that holds a custodial scope and structure?*



It is a pity indeed to have to ask these questions particularly if the failure is the lack of appropriate documentation rather than the actual practice itself. Perhaps the problem lies in the fact that nurses are the professionals who spend the longest time with care receivers on a daily basis (Wright, 2012, sec.6). This may render the therapeutic alliance to be more informal than that seen with other professionals and consequently, the interactions within it may be perceived as not needing to be strictly and formally documented. However, it is still felt to be a failure to negate the professionalism and importance of such an alliance. Contrastingly, Westbrook, Duffield, Li and Creswick (2011) identified the length of time spent with care receivers as one of the greatest strengths of the nurse-care receiver alliance since it may provide ample time for maintaining the alliance and hence reaching therapeutic goals (p.319). In this light, failing to provide a formal documented structure of the alliance and the interactions within it is indeed a loss for care receiver-care as well as for the mental health nursing profession. A myriad of other possibilities can be explored if the identified problem is simply the lack of proper documentation – these include time-management difficulties, staff shortage, alienation, working on auto-pilot and attitude/ motivation problems.

Still, the concerns do not halt here since other aspects of the analysis of the data may introduce caution against firmly writing off this minimalistic approach as being a problem that is solely linked to the documentation procedure rather than the actual nursing practice. For instance, when asked about their interaction with different professionals and the activities that are carried out within the alliance, most of the care receivers were clearly at a loss to describe the therapeutic activities that they do with nurses. A look at the interview excerpts that describe nursing interactions show that most of the care receiver statements feature custodialism or lack of therapeutic activities:

I feel well when I am with the nurses. We share jokes. They take me out to the main garden. [CR2:28]

I relate to nurses when for instance, I ask them for some hot water to make coffee. Nothing special. Nurses do not offer any treatment or try to help with the symptoms. I never had any relationship with any nurse where I disclosed my feelings or talked about my symptoms. We just speak about stuff related to computers. [CR1:59]

My relationship with the nurses: When I speak to the nurses about my medication, they inform me that they have to do what the doctor says. They say that the doctor wants me to have it and so they will give it to me even if I do not want to. [CR4:22]

Mostly it is “Hello” and “Thank you” with the nurses. Sometimes I open up with them but they say: “You will get better. You have a husband who loves you and respects you. Be brave so that you get out of here.” [CR5:31]

What do you mean? I do not have sessions with the nurses. The nurses are here all day and so am I. So sometimes we speak..or if I need to ask anything, I go to the nurses’ room. I approach them and ask whatever I need to ask. Usually it is about permission to do something. Or to ask about what is going to happen. [CR10:34-35]

Contrastingly, but to a lesser extent, some of the participants did refer to nurses who gave prominence to therapeutic activities such as Care Receiver 4 who stated that:

There are some nurses who give you psychological therapy themselves because they explain to you, speak to you gently and make sure that you understand. Even during their break time. [CR4:23]

Care Receiver 7 made a similar reference by pointing out that:

The nurses are very good, very nice....they try to discipline you slightly. And they are right, you know. Nurse X tries to do it. We hate it but at the same time it is good, you know. She tells us to get the heck out of our bed and we’re all trying to find our way around. She helps us to get our act together. So she’s good, you know. [CR7:25]

Another aspect of the analysis which may give rise to speculations about the therapeutic alliance in practice involves notable discrepancies that were evident between the nursing reports and the medical reports relating to the same care receiver during the same period. For instance, in the medical file, one doctor described a series of events related to Care Receiver 1 by writing that:

Patient after ward round is getting verbally aggressive.  
Threatening ++  
Says he wants to die + slash his neck  
Plan: 1). Level 1 supervision  
2). If space available, kindly transfer patient to Ward X [MR1:E1]

Contrastingly, the day and night nursing reports of the same care receiver on the same day did not report any of these events and simply stated:

Day report: Level 1 converted as per protocol and maintained by Nurse X. Treatment given.

Night report: Slept well. Level 1 covered by Nurse X. Slept well. [NR1: 23-24]

Another example was the day nursing report related to Care Receiver 2:

Seen by Dr.X. Treatment reviewed. Repeat serum Epilim next Sunday. Review next Saturday to consider leave. Main Garden permission + OT accompanied. OT informed. [NR2:8]

On the other hand, the medical report on the same day mentioned additional observations such as:

*(Care receiver)* remains slightly elated, overtalkative with paranoid ideation Thoughts of revenge/ harming others [MR2:E3]

These are only two examples out of many comparisons between nursing reports (that describe a quasi-eventless care receiver existence consisting of comfortable days and nights) and the counterpart medical records that despite still being considered as minimalistic in nature, at least include some other details pertaining to the care receiver's state. Once more, the three questions that I asked earlier shift back in focus and sadly have to remain linked to postulations rather than to definite answers within the perimeters of this research study. A final glance at the minimalistic discourse-type and its subject positions does not fail to outline the knowledge-power interface that may shape the therapeutic alliance. This is due to the fact that being minimalistic is not simply the act of being brief. More importantly, it embodies the professional with the privilege and luxury of selecting the content - that which is to be included or excluded within the confinements of the therapeutic alliance. As an example, on referring to the last excerpt that has just been presented, we can note that the nurse who wrote the report decided to omit the fact that during the same day that is being described, the care receiver may have had thoughts of revenge and harming others in view of paranoid ideations. Once again, I speculate how such

information, which may be deemed as being considerably important in the provision of appropriate nursing care, failed to merit an inclusion in the report. Foucault (1974/2008) may have proposed an answer to this question when he stated that by functioning as a disciplinary system, the psychiatric hospital may commonly exclude the “crisis of madness”: “The main instruction, the main technique of this asylum discipline is: Don’t think about it. Don’t think about it; think about something else; read, work, go into the fields, but anyway, don’t think about your madness” (p.249).

Thus, the nurse who wrote this report may have preferred to ignore the care receiver’s crisis and opted for “ethical uniformity”— a term used by Foucault in his reference to the practice of encouraging uniformity and routine amongst subjects within a disciplinary system (Foucault, 1961/2001, p.244). Moreover there was no indication of the way that this care receiver state was being addressed within the nurse-care receiver alliance. In this manner, the nurse was using his/ her superior power linked to his/her knowledge (or lack of) about the person’s state to convey information that would inevitably shape care. This is felt to outline a serious knowledge/ power imbalance in the associated alliance since the professional seems to hold the veto on what to report, sometimes trading off the importance of the care receiver’s voice and personal experience in the process. On reflection, I view these subject positions and consequences within the alliance as being directly linked to those present within depersonalising discourse which shall now be explored.

The main subject position occupied by the professional who indulges in depersonalising discourse features him/her in instances whereby s/he knowingly or unknowingly removes the person out of the care receiver. Perhaps this leads to feelings such as those expressed by one of the care receivers during the interview:

I feel as if I am not treated as a person. I wish that they would speak TO ME. Explain TO ME. Show ME, tell ME where I’m not acting as I should, what I am doing that’s wrong...To treat me like an intelligent human being, which I think I am. [CR9:21]

When I reflect upon those excerpts in the medical/nursing records that are characterised by depersonalising discourse, my main concern arises from the fact

that the professionals' written words were so lacking in their portrayal of the care receiver as a unique human being. I would like to highlight this problem by comparing and contrasting an excerpt from one of the nursing records to an excerpt from a technician's report about a car. Let us then start by first reviewing the excerpt taken from the technician's report:

Let's start with the looks. It may be the first MINI measuring over four metres and the first modern MINI with four doors, but there's no doubt which family the Countryman belongs to, thanks to the cartoonish face and those familiar proportions. The roof looks stuck on, which is a MINI trademark, but the glasshouse is unique. It's as though there are two segments – front and rear – merging at the C pillars. Our Cooper S test car wore 17-inch rims. The controls are all brilliantly intuitive, so much so that we're trying hard to refrain from using motoring cliches such as 'extension of your limbs'. The zero slack steering is very quick and the resulting turn in response sharp, and yet it retains enough composure and stability at high speeds to not feel nervous. There's a constant supply of feedback, too, and torque steer isn't that big a distraction, just little tugs at full throttle. The brake pedal feels natural, is easy to modulate and the stopping power is strong (Tan, 2011, para. 5-18).

The question that can be asked here is: *What do the written words indicate about the qualities and uniqueness of the car under observation?* As an answer, it can be stated that the technician dedicated considerable effort in describing the intricate details of the car's appearance, performance and security, to mention but a few of the areas that are explored in the full review. Moreover, just by reading the above excerpt, one can easily realise, even if not informed by other sources, that the object in discussion is a car. This identification is possible due to the description of those combined details that make up a car such as: the type of outer body, the steering wheel, the rims, the doors and the brake pedals. One can also tell that the specific type of car is a MINI Cooper, as noted in the report by the writer's specific references to the car by its actual brand name.

On the same lines, we can now repeat this exercise by looking at most of the content of the majority of the Nursing Reports included in this study (Care Receivers 6 and 9 being the exceptions). The following is a typical 3-day excerpt taken from one of the reports:

Night report: New patient admitted today at 8pm informally by Dr.X. Seen by Dr.X. Valium regime as per chart. Routine bloods (no forms filled). Alcohol withdrawal charting. Review by firm.

Day report: Treatment given.

Night report: Treatment given. Slept well.

Day report: Treatment given. Seen by social worker (from rehab unit) today.

Night report: Comfortable night.

Day report: Treatment given as prescribed. Comfortable day.

Night report: Comfortable night. [NR3:1-7]

As in the car exercise, the question that is being asked is: *What do the written words indicate about the qualities and uniqueness of the person under observation?* The answer outlines an immediate contrast between the two reports. Primarily, it is felt that the above excerpt which incidentally, is a typicality and not an exception of the information provided by most nursing reports in this study, fails to clearly indicate whether the object in discussion is a person or not. Thus, for example, one can easily apply the above report to veterinary medicine where the entity under observation would be an animal rather than a person. I feel that the alarming and painful conclusion that emerges from this comparative exercise is that whilst an inanimate object such as a car can be afforded such rich and detailed wording, a human being can be reduced to crude descriptions that hardly provide anything more than very basic information. Needless to say, in the excerpt from the nursing report, there was no reference to the specific person due to lack of reference to the person's actual name and his/her unique characteristics. The almost complete lack of use of the care receivers' names in the records located was surprising to me. During the interviews, one of the care receivers, whose name did not feature in any of her medical/nursing records, referred to this when she spoke about the name usage by different professionals:

The nurses call me by my surname not by my name. It is: "Hey hey \*surname\*, come here." I do not care, I just get on. The occupational therapists refer to me by my name, yeah they do. The psychiatrist refers to

me by my name too. It is just the nurses who refer to me by one of my surnames. And a couple of patients do that too. It doesn't bother me because I know who I am. And I do not care who thinks what and who doesn't think what. I am just as good as anybody else here. [CR7:37]

Interestingly, despite the care receiver's stated conviction that she is not bothered by the fact that the nurses refer to her by the use of her surname instead of her name, her non-verbals indicated otherwise. Moreover, as the interview progressed, the care receiver declared that out of the three professional-types mentioned in the excerpt above, she perceives the greatest power imbalance to be present in her alliances with the nurses. I wonder then whether the lack of use of a person's name may be associated with a barrier that serves to separate the two entities within the alliance by creating different power levels.

Similar findings were presented in an analytic study of nursing documentation by Heartfield (1996, p.101). The researcher noted that on admission to a hospital, the individual seems to lose part of his/her identity. This can be seen by the assignment of labels such as "patient" or any other description that omits the actual name of the person. In Foucault's world, this would be the person who is being recreated as a passive object in the face of subjugation: "We can say that disciplinary power...fabricates subjected bodies: it pins the subject function exactly to the body...the individual is nothing other than the subjected body" (Foucault, 1973/2008, p.55).

On reviewing the medical records that were characterized by depersonalisation discourse, it can be noted that at least, and in contrast to the majority of the content of the nursing reports located, one can tell that the entity in discussion is a person. However, it is still felt that reference to the individuality of the person features poorly and is instead engulfed by writing that is governed by pathological discourse. Hence, in his description of a particular interaction with Care Receiver 5, a doctor reported that:

Patient is in a low mood  
Concerned because husband threw out her clothes and she feels she has lost part of her.  
Has death wishes but no suicidal thoughts

Plan: A clear programme should be established with OT about how the patient spends her day [MR5:E1]

Perhaps this may shed light on why during the interview, Care Receiver 5 expressed her discontentment with the alliance that she has with her psychiatrist due to the feeling of fear that he instils in her. She described how she will do whatever the doctors suggests without any questions or doubts since she is too scared to do otherwise. Similarly, the full report of one of Care Receiver 7's medical reviews was presented as follows:

Ward round with consultant psychiatrist  
Patient complaining of memory loss, fatigue  
Stable, euthymic

Plan: Bloods, Bio, ESR, B12, Folate  
MMSE  
TFT s, VDRL, Ca 2+, Phosphate [MR7:E3]

On a similar basis as that highlighted in the section related to minimalistic discourse-type, one cannot automatically assume that a writing manner characterized by depersonalisation is a direct reflection of the same style of therapeutic alliance. As a discourse-type, depersonalization may be linked to various possible rationales such as learned ways of writing/practice, time management, mindlessness, lack of knowledge and attitude /motivational issues. Hence, the experience of the professional occupying this position may be one characterized by professionalism, expertise and efficiency if, for instance, the rationale is related to learned ways of practice/writing and time management. If the reason for indulgence in this discourse-type is lack of knowledge, then the professional may be limiting himself/herself to the wording and practice that s/he is familiar with and this may perhaps lead to a custodial and defensive type of alliance. Similarly if depersonalising discourse is a direct result of an attitude/motivational issue, it may be the case that in the face of suffering and in an environment that can be psychologically distressing for the professional, s/he opts to deal with what s/he perceives as a 'non-person'. As discussed in the first theme that featured in this section, the latter may very well be an example of a self-protecting mechanism in an attempt to prevent one's burn out. Finally, it may be useful to reflect on the cultural contribution that may be affecting the professionals' perception of the care receivers



in their care. As discussed in the introductory part of this thesis, in Malta, mental distress is nowadays much more accepted than it had been before the past decade. However, I still feel as if the general view is that this type of distress is mostly linked to the lower social class or to individuals who have not managed their life in an appropriate manner. This often seems to drive a wedge between ‘us’ and ‘them’ – the ‘mad people locked up in the asylum with no real hope of a successful future’ and ‘us who are out here behaving normally and managing our life as we should be managing it’. I believe that these are dangerous views that may lead to the separation of the ‘human’ and the ‘non-human’ and to rather rigid ways of determining the characteristics which one needs to have to be classified as human and be treated as such.

## **Conclusion**

Conclusively, it is felt to be rather odd for a professional to indulge in such a cold and mechanical manner of writing whilst describing an alliance that is supposedly care receiver-centered and targeted towards independence and recovery. In actual practice, is the care receiver simply a chess pawn who is transferred to other wards, sent on leave and brought back as necessary? Is this Foucault’s subjected body?

Perhaps some of the themes that emerged from the care receivers’ interviews, particularly those which form the *Resentment-Opposition* alliance type could be a result of the use of depersonalising discourse from the professionals’ part. Surprisingly though, it has to be mentioned that out of 27 identified alliances by the care receivers, only five were categorized underneath the *Resentment-Opposition* alliance-type, which is the only type where care receivers are dissatisfied with the power-balance in the alliance. Perhaps this relates to Foucault’s contention that power may not necessarily be negative and it does not automatically lead to repression. This is because it can also produce reality, ritual and knowledge (Foucault, 1978/1990, p.93). Consequently, this may indicate that depersonalising discourse does not necessarily result in care receiver dissatisfaction. However, it is important to note that care receiver satisfaction with the knowledge-power balance may not be the sole indicator of positive therapeutic outcomes or a definite track to

recovery. This has been explored in more detail in Section 4.2 that was dedicated to the discussion and analysis of the interviews transcripts.

### **Theme 3: The Humanistic Approach**

#### **Introduction**

The third theme that was identified from the medical and nursing records may be perceived as a stark contrast to the two other discursive themes that emerged from the professionals' texts. In this context, humanism describes a professional's approach which, to an extent, places emphasis on the value of individuality, personal meaning and holistic care. On the same note, in the humanistic approach, there is less preoccupation with pathological and depersonalising discourse which subsequently leads to less evidence of authoritarian discourse in the texts. It has to be noted that this discursive theme is the theme that featured the least in the records reviewed and it presented with a similar frequency in both medical and nursing records within this study.

#### **Description**

On exploring those professionals' texts which contributed to this theme, it could be noted that the alliance was being constructed through a number of direct and indirect references. One nurse's report about care planning with Care Receiver 6 implied the practice of shared decision making or mutual involvement within the alliance by stating that:

Plan: Patient agreed to above plan - leave for 1 week from today. To come next Wednesday evening and to sleep here. To give feedback on Thursday to firm. [NR6:4]

Similarly, another nurse hinted at an alliance that is, at least partially, constructed on collaboration by reporting that:

Patient agreed and went on leave with her husband this afternoon - to return on Sunday evening. [NR6:7]

Finally, in this theme, the therapeutic alliance appears to be characterised by a professional who affords considerable importance to the care receiver's subjective experience and wishes. For instance, a doctor described Care Receiver 5's state and actions by documenting that:

Patient is being empowered through cooking. Visited daily by her husband. Went to visit her house and she was much less anxious. Feels she lacks motivation, wants to go home but claims she needs to feel better before. Feels afraid with low mood at times. Has started seeing the psychologist. [MR5:E5]

Following a review of the constructions of the alliance within the humanistic niche, three main discourse-types appear to be contributing to the existence of this theme.

The first discourse that can be identified is that of **equality discourse**. This features as a way of writing about the therapeutic alliance in a manner that indicates a balance of knowledge and power in the interactions described. In this way, it appears as if the care receiver's feedback has weight and is at times taken on board in care planning. This discourse-type is reflected in some of the texts written by professionals, such as:

Patient agreed to be transferred to Ward X as space is now available as planned by firm. [MR1:E2]

Patient says that he has been going to OT every day.....says he is fed up about being in the ward. [MR2:E6]

Patient would not approve of increase in treatment. Plan: To offer psychotherapy. Behavioural advice given regarding coping with bullying, continue same treatment. [MR5:E4]

In a parallel manner, **humanistic discourse** is also being employed. This can be contrasted with the depersonalising and minimalistic discourse types that have been discussed in the previous two themes within this section. Incidentally, the terminology used within this discourse-type tends to be less clinical and more informative as well as being based on a humane approach that more or less addresses the care receiver as a unique and valuable figure. It seems as if this resembles normalising approaches such as that advised by Romme (2007): "Accepting is not

concretely accepting everything...but it is the beginning of looking differently, creating hope and opening personal possibilities.” (sec.3).

In particular, this is the only discourse identified within the texts which featured the use of the care receiver’s actual name rather than references by use of the third person, as seen in the following excerpt:

Medical officer on call at hospital

*(Care receiver’s name)* has come back early from leave.

Husband: *(Care receiver’s name)* has been agitated at home for the past 2 days since she went out on leave. Not sleeping. Depressed, crying. No paranoia.

*(Care receiver’s name)*: Feels depressed but can’t explain why. Anegia, anhedonia. Hopelessness, decreased appetite. Not sleeping. Bed seeking behaviour. No psychotic features, no death wishes, no suicidal wishes.

[MR6:E1]

The care receiver who features in the above excerpt is one who spoke about her psychiatrist in a positive manner and indicated her overall satisfaction with the alliance – in fact this led to the alliance being classified as a *Satisfaction-Alliance* type. Perhaps then it may be suggested that there is a link between the professional’s way of writing (mentioning the person’s actual name and elaborating on the care receiver’s subjective experiences) and the care receiver’s positive perception of the alliance. On reflection, it seems as if the humanistic discursive theme is also hosting a **recovery discourse-type** by presenting a professional who is *walking alongside the care receiver* rather than *walking the care receiver* or *walking over the care receiver*. This can be likened to descriptions of care models that are based on the Recovery Model – these focus on the individual’s abilities rather than the disabilities related to symptoms of mental illness (Allott, Loganathan & Fulford, 2002, p.13). On looking at excerpts that are characterised by this discourse, it can be noted that to some extent, the care receiver is being regarded as an able individual who is expected to participate in care as an active stakeholder. Moreover, in one of the excerpts, the professional transcribed the care receiver’s own words:

Talks about her husband, hurt that he threw away her things but then justified his actions and anger. When he brought her home, his friends were telling

him: “Ghalfejn gibtha lura? Ghax ma hallejtiex fejn kienet?” (*Why have you brought her back? Why didn't you leave her where she was?*) When she envisions her future going back home, she feels anxious. [MR5:E3]

Interestingly, this is the only example of direct use of the care receiver's voice that could be located in the medical and nursing records included in this study.

On dedicating attention to the positions offered by these three discourse-types, equality discourse may primarily be explored. In this case, despite the obvious difference that the professional is providing a service and the care receiver is the recipient of this service, there seems to be little more to distinguish between the two entities. As a prime example, it may be insightful to consider the responsibility for care outcomes – in fact, it can be contended that in this equalitarian system, both parties are responsible to ‘make it work’. Moreover, it seems to be mutually agreed that all knowledge is considered, irrelevant of the source, and hence, this is felt to be what makes the alliance a place for practice, a safe area. Although the professionals were not interviewed, the main feelings that could be elicited from reviewing the excerpts from the records were those of humbleness, readiness for collaboration and comfort in one's professional skin.

The second discourse-type identified, namely the humanistic discourse, gives rise to a number of positions that are felt to complement the concept of equality that has just been discussed. Figuratively speaking, equalitarian discourse may be viewed as being a platform for humanistic discourse since probably, the latter would not be meaningful without the former. In practical terms, this implies that the alliance can only be built on a holistic approach if both entities within it hold an equal seat in the turntable of events. The professional who indulges in humanistic discourse may be seen as being in a position where the illness is not the governing body of the alliance and the care receiver is much more than the sum of his psychiatric symptoms. This type of discourse may be similar to that advocated by Deegan (1996): “Rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings” (p.92).

Rather than viewing the illness as a set diagnosis that requires a standard treatment package, the scope of the alliance goes beyond and attempts to target recovery in

wider terms rather than simply as a resolution of the symptoms. Here an element of confusion may prevail because this seems to overlap on the recovery discourse that has been alluded to earlier. In fact, this is understandable because the positions offered by these two discourse-types share many similarities and are in fact constructed on each other. In a collective look at the positions offered by these two discourse-types, the professionals seem to be unearthing what is felt to be an important aspect in the mechanism of the system. This refers to the recognition that the aim of the therapeutic alliance is not only to provide a medical answer to a clinical question. Rather, it is a tool that facilitates a journey of self-growth by the care receiver and professional alike. As a result, this may lead to discoveries, new knowledge and venues that are unlike those encountered prior to embarking onto this recovery path. It is a journey that most importantly, is not thoroughly pre-planned on basis of previous experiences (of the professional) within other alliances. In his guidebook about recovery-based care, Slade (2009) differentiated between *clinical recovery* – referring to getting rid of symptoms; and *personal recovery* – relating to the attainment of meaning, values and personal goals irrelevant of whether the symptoms of mental illness have resolved or not (p.4). Furthermore, the author discussed how personal recovery is specific and unique to every individual. In addition, I contend that the meaning of recovery is specific not only to each care receiver but also to the therapeutic alliance itself as formed by two entities during the process of being allies. This suggests unity – not simply in the face of mental illness- but more of a positive process that leads to a higher level - a better place.

## **Conclusion**

Notably, this is the only occasion in the data collected where the care receiver's actual name and direct words found their way in the medical and nursing records. Perhaps for some, like myself, this adds colour to a black and white portrait and a breath of life to what may otherwise be a cold and pathological scripture. But then for others, this writing style and attitude may be deemed as unprofessional, maybe too personal or generally undesirable. This may explain its minimal appearance within the medical and nursing records that were examined.

#### 4.3.4 Conclusion

The findings that emerged from the analysis and discussion of the medical and nursing records have helped to explore some of the discourses related to the ways that different care providers may perceive the knowledge-power balance in the therapeutic alliance.

On a final note, it seems as if the findings that emerged from this part of the study may bear resemblance to those reported in a study carried out by Bjorkdahl, Palmstierna and Hansebo (2010). In their study, the researchers explored caring aspects of nursing care in acute psychiatric settings and classified the two main caring approaches that emerged as the *ballet dancer* and the *bulldozer*. The ballet dancer approach signified a caring approach that emphasised the cultivation of safety and trust. The sub-themes identified were: signalling a caring approach, putting yourself in the care receiver's shoes and using yourself as a finely tuned instrument (p.512). This may reflect the third theme that emerged from the professionals' written records in the current study – the Humanistic Approach. Bjorkdahl et al. (2010) described the bulldozer approach as a type of care that tends to treat the care receiver as an object that can be controlled by the bulldozer (p.513). In this case, some of the sub-themes identified were: guarding the ward from chaos, ensuring sufficient power, justifying the use of controlling actions and keeping a critical mind. This approach may bear some resemblance to the first and second discursive themes that I have identified in the medical and nursing records – The Pathological Lens and Depersonalisation.

## **4.4 Developing the effectiveness of the therapeutic alliance**

### **4.4.1 Introduction**

This part of the chapter concerns the identification of direct and indirect references in the findings to knowledge required by both entities in the alliance for power to be managed in a manner that enhances therapeutic outcomes. This is intended to generate information for answering the second sub-question leading this study while simultaneously allowing recommendations to be made in view of the findings as perceived by the researcher.

During the interviews that took place in the first phase of the study, the care receivers were asked specific questions that were targeted to elicit information about the type of knowledge required by care providers and by themselves for power to be managed in a manner that enhances therapeutic outcomes (Refer to Appendix 1). Furthermore, useful information in this regard could also be extrapolated from other areas within the coded interview transcripts that were not specifically related to direct questions about the perceived knowledge required.

Since the second phase of the study consisted of document analysis, a direct answer regarding the knowledge required could not be obtained from this source in the same way that it had been obtained by means of the direct questions posed during the interviews with the care receivers. Nonetheless, data relevant to answer this research sub-question could be extrapolated from the medical and nursing records that were reviewed. In this regard, the excerpt examples that have been presented in this part of the chapter may help to clarify and link these extrapolations to my interpretation and recommendations.

This chapter has been divided into two main sections which explore the knowledge needs of the care receivers and the care providers within the alliance, respectively. Within each of the sections, the discussion has been structured by a thematic approach as follows:



Care receiver knowledge needs:

- Theme 1: Empowerment

Care provider knowledge needs:

- Theme 1: Humanism
- Theme 2: A Tailor-Made Approach

Each of these two sections shall be addressed by using data collected from both of the data sources in the study. Thus, for instance, information about the knowledge required by the care receivers was provided by the care receivers themselves as well as extrapolated by the researcher from the medical and nursing records. Similarly both sources provided valuable data on the knowledge that may be required by the care providers.

The following table depicts the sections and their themes, a brief descriptor of each theme and a number of excerpts which highlight the rationale for each of the themes. The final column depicts the areas of knowledge that may need to be developed in training and practice in relation to each respective theme. More excerpts have also been included in the discussion that follows.

Table 5: Summary of findings and recommendations related to knowledge required by care receivers and care providers

Entity	Theme	Excerpt examples that highlight rationale for theme related to type of knowledge required	Areas of knowledge that need development
<p><b>Care receivers</b></p>	<p><b>Empowerment</b></p> <p>This theme is concerned with the need of knowledge related to self-empowerment. It may involve learning how to acknowledge inherent resources, being aware of the current situation as well as communicating assertively within therapeutic alliances.</p>	<p><i>I do not know anything - like when I'm going on leave, how much time I will be spending here - I do not know anything. [CR1:27]</i></p> <p><i>Professionals cannot learn from me. I am zero, stupid. How can they learn from me? [CR5:34]</i></p> <p><i>With the psychiatrist, the power imbalance is there because I am the crazy one with no knowledge at all, I do not know. His opinion is that since I did such an overdose, he cannot discuss with me. And so I reflect that I may have brought this onto myself and so I have to be submissive. [CR9:35]</i></p>	<p>‘Amour de soi’</p> <p>Mindfulness</p> <p>Assertiveness</p>
<p><b>Care providers</b></p>	<p><b>Humanism</b></p> <p>This features the need for some of the care providers to learn how to engage in behaviour that places the care receiver at the forefront by actions that are targeted towards the individual’s personal recovery.</p>	<p><i>I am not satisfied. I wish that before they prescribe medicine, they ask the patient whether he wants it or not. And the patient has every right...the patient can decide what type of treatment he wants to have and the doctor has to co-operate with him not just force him to take medication. [CR4:30]</i></p> <p><i>I feel as if I am not treated as a person. I wish that they would speak TO ME. Explain TO ME...to treat me like an intelligent human being, which I think I am. [CR9:21]</i></p>	<p>Civil behaviour</p> <p>Mindfulness</p>

Care providers contd.		<p><i>The nurses need to be educated - basic education about how to interact with people, people who are at our level, who suffer from depression...patients do not speak because nurses snap at them and that destroys all the trust. They (the nurses) need to speak to you not tell you the contrary. [CR6:34]</i></p>	
	<p><b>A Tailor-Made Approach (Based on multiple treatment options stemming from orthodox &amp; complementary/alternative modalities)</b></p> <p>This concerns that type of knowledge that may be required by some care providers in relation to the need to embrace the concepts of individualism and diversity whilst building alliances with different care receivers.</p>	<p><i>Professionals need to learn that not everyone is the same.... Because here they have different types of patients. And sometimes it seems as if all patients are the same. [CR3:39]</i></p> <p><i>Professionals need to realise that everyone's mind is different - a mind problem is worse than having cancer. [CR1:73]</i></p>	<p>Individualism</p> <p>Diversity</p>

## 4.4.2 Potential knowledge that may be required by care receivers

### Theme 1: Empowerment

#### Introduction

This theme is concerned with the potential need of some of the care receivers to acquire more knowledge about self-empowerment. This may involve learning how to acknowledge inherent resources, being aware of their current position as well as communicating assertively within therapeutic alliances.

#### Discussion

The care receivers' knowledge needs in relation to this theme have been constructed in a number of ways. At times, the data collected implied that some of the care receivers may benefit from enhanced awareness of their self-worth:

The hospital was the only option that I had. I did not know about anything else - I had always been in the fields, I did not know about anything. [CR5:9]

I am fine with the idea that I have less power than they (*the nurses*) do. It is how things should be. This is because they are the ones in charge and know how things should be done, not me. [CR1:67]

In this manner, the knowledge required is being constructed as the need for some of the care receivers to acknowledge and use their expertise within the alliance.

Knowledge required by some of the care receivers may have also been constructed in terms of the need for enhanced awareness about the current moment: to capture the *here and now* as opposed to automatically drifting along the recovery journey:

I do not know anything - like when I'm going on leave, how much time I will be spending here - I do not know anything. [CR1:27]

I do not think that I am involved in my care planning but I do not have any will to be involved. [CR5:20]

Another construction of the knowledge needed may pertain to clearer awareness of one's rights and the ability to stand up for oneself within therapeutic alliances:

During the ward round, they just tell you what is going to happen, what you are going to do. [CR6:16]

With the psychiatrist, the power imbalance is there because I am the crazy one with no knowledge at all, I do not know. His opinion is that since I did such an overdose, he cannot discuss with me. And so I reflect that I may have brought this onto myself and so I have to be submissive. [CR9:35]

These descriptions of the knowledge required may be perceived as being linked to three main areas which need to be developed in training and practice. These are: **'amour de soi', mindfulness and assertiveness** – these shall now be explored.

'Amour de soi' is the first knowledge need that I have identified from the findings. This concept, which is one of the principal elements in Rousseau's moral psychology, refers to a natural sentiment that involves self-love, self-preservation and self-importance (Rousseau, 1754, p.73). This can be contrasted with 'amour propre' which refers to the "social sentiment which moves us to seek the good opinion of others and to value our status relative to others" (Bertram, 2010, para.6). In the context of this study, discourse may have highlighted some of the care receivers' need to acquire knowledge about self-worth and to acknowledge their important position within the alliance. For instance, this was identified when Care Receiver 5 stated:

Professionals cannot learn from me. I am zero, stupid. How can they learn from me? [CR5:34]

Care Receivers 1 and 9 expressed similar views:

I am not at all an expert in my own care...I wish! I do not have enough knowledge. [CR9:36]

I do not know much about pills, I am not an expert in my care. I do not think that professionals can learn anything from me. [CR1:68,69]

The second knowledge need that may be seen as emerging from the data is related to mindfulness. This refers to some of the care receivers' need to acquire knowledge on how to focus attention and reflect on the present moment (Black, 2011, p.1). The importance of this kind of knowledge may be seen in the need to empower some of the care receivers to have more awareness of their current position, rationale behind actions carried out and consequences of these actions on self and others. I feel that enhanced mindfulness in relation to these actions may then limit some of the passivity and compliance that were at times detected in the data collected from some of the care receivers:

Regarding symptoms: I still do not know exactly what I have. [CR9:9]

I do not know what the plan is but I guess that in 2 weeks' time I will be out. [CR2:16]

They need to teach me about the treatment, about life. This would make me more aware of what I should or should not do. [CR2:34]

In his report about Care Receiver 2, a doctor may have also identified the need for care receive knowledge about mindfulness when he wrote:

Patient and friend do not know exactly how he takes his medication. [MR2:E1]

Contrastingly, some of the care receivers who were interviewed seemed to grasp the importance of mindfulness by actively incorporating it in their recovery:

There is something which has been on my mind for a long time and I have tested it to see if it is true or not. When you get a wallop of depression, and you go to lie down. Before you lie down, something in your mind says: "Are you going to lie down or are you going to fight it? Are you going to lie down for 11 hours or are you going to fight it? Are you going to have something to eat and fight it?" So you have a choice. So you may say: "I will eat something later to watch my weight. As long as I do not lie down." Because once I lie down, I am in bed for 24 hours sometimes. But I have to control it and let myself know that this is it. I have a choice. I can either lie down in bed or I am going to cope with it. [CR7:15]

But I believe that you need to pass through phases. Here I have learned certain things - there is cure here, not cure as such because there is nothing much to do here apart from sitting down and watching TV, no activities. So I

just need to spend a few days here to get clean, take the medication and get on with my life. [CR3:15]

You need to know yourself..what is happening to you. You need to read up about your illness because only then you can get an idea of what is happening. That can be a problem because not everyone has access to the internet or to books and some of the information is a bit too complicated. [CR10:46]

The third knowledge need identified is related to assertiveness. This refers to some of the care receivers' need to acquire knowledge on exhibiting behaviour characterized by a confident assertion of one's rights or perception. This is done without aggressively imposing upon the rights of others or submissively allowing others to deny one's rights or perception (Willett, 2009, p.83). This need was identified from excerpts such as the one from the interviews with Care Receivers 1 and 9:

Then as I said, my husband intervened and said that he agrees with the option that I do not take any pills this week. And this is what happened. I did not really have a choice then. Because since that was what my husband wanted, obviously, the psychiatrist would be listening to him and doing as he said. [CR9:18]

With the psychiatrist, the power imbalance is there because I am the crazy one with no knowledge at all, I do not know. His opinion is that since I did such an overdose, he cannot discuss with me. And so I reflect that I may have brought this onto myself and so I have to be submissive. [CR9:35]

They had stopped the Effexor and started to get its generic instead. From then onwards, I had started to deteriorate. I had once discussed this with someone but nothing was done. I could not do anything else then. If he (*the consultant psychiatrist*) said that I need to take it, I have to take it. [CR1:52]

But it is obvious that they know much more than I do. That is why they work here. They run the hospital and the hospital is theirs. That is why they are in charge of what happens to the hospital, to me and to the other patients. It is life, eh? Like if you are a student and you go to school, your teachers are much more powerful than you are. But then the head teacher is more powerful than THEY are. And whilst I am living in Malta, the prime minister is more powerful than I am. It is the natural way of things, I think. [CR10:38]

Additionally, some of the medical and nursing records included provided examples that may serve to highlight the need for care receivers' knowledge about assertiveness:

Dr.X came to see patient and wanted to send her back on leave but patient refused and instead went running to the Occupational Therapy premises but was brought back to the nursing staff. Dr.X was again informed and decided to send her for 3 days on leave. [NR6:7]

Conversely, descriptions provided by some of the care receivers showed awareness and practice of assertive behaviour:

I formed this care plan - this was what I had told my doctor and social worker - what care plan I wanted..not going out of hospital to my home and then the programme - I want to go to the programme directly from here. I will get back into the programme - not continue from where I left because you cannot do that if you stopped. You have to start all over again. I do not mind - instead of spending a year in the programme, I will spend more in total. That is a bonus for me. It was all my decision. [CR3:23]

I wouldn't be afraid of asking questions, whoever the professional is, it can be the prime minister! [CR3:35]

If I give suggestions, I get feedback, good, bad - it was never bad. Then I have to accept. Not 'accept' because 'accept' can imply that I just submit to everything but in the situation of a patient, she is not going to say something that will hurt me. She will lay out the options and feedback and ask me what I think about it. I have time to discuss. I am not presented with a rigid answer. [CR3:30]

I do not need any support. I can support myself. But I need legal help to help me with this medication issue. [CR4:34]

The doctor had wanted to admit me to this hospital but I had refused since I was pregnant. And I did not feel as if I required treatment here. [CR5:1]

But you also have to be confident and have the guts and energy to speak for yourself and participate. [CR10:46]

Since these three main types of knowledge needs are felt to be overlapping and complementary, their characteristics are now going to be discussed collectively.



As a starting point, it seems to me as if the three areas identified can be viewed as describing a step-by-step approach in addressing the knowledge that may be required by some care receivers to manage the knowledge-power balance within the alliance. In this manner, the type of knowledge described by ‘amour de soi’ may be seen as being the first that may be provided as this may help to enhance the individual’s self-importance and self-love. Knowledge related to mindfulness may then follow with the main aim of prompting the person to focus on the present moment and then situate his/her current situation within plans for the future. Finally, knowledge pertaining to assertiveness, may be offered as this may help the individual to be an active participant within the alliance by being able to communicate self-needs in relation to the current moment as well as to the future.

A review of the literature shows that there are several available tools and techniques which can be used in the practical setting to guide care receivers in accessing the three different types of knowledge that have been identified. For instance, self-awareness exercises may contribute to addressing knowledge related to ‘amour de soi’. This includes activities such as *life-story work* (See: Making Waves, 2009), *SWOT analysis* (See: Mindtools, 1996), *Johari window* (See: Chapman, 2003) and *reflective writing* (See: Bolton, 2010). As described by Slade (2009), the aim is to guide the care receiver in the creation of a positive identity that is based on strengths and resources, inherent knowledge, dreams, goals and aspirations rather than pathology and compliance (p.14). Other tools like the *Strengths Model*, the *Tidal Model*, the *Values in Action Inventory of Strengths* and *Wellness Recovery Action Planning (WRAP)* may also be useful in this regard and can be implemented in one-to-one sessions or adapted to group work (Slade, 2009). During the interviews, it was noted that the majority of the care receivers were reluctant to view themselves as being experts although some were ready to concede that they may be partial knowers in the alliance. However, it may be the case that that some of the care receivers in my study may have understood the term ‘expertise’ as referring only to knowledge that originates from academia and professional experience whilst disregarding the type of expertise related to the personal experience of being a care receiver. Surprisingly, despite this apparent poor-moderate self-perception about expertise, most of the care receivers stated that they would be willing to share their knowledge

with the professionals. Furthermore they elaborated on the kind of knowledge that they may share:

Professionals can learn from me and I would be willing to share with them. I can teach them how to treat patients because I am a patient. [CR6:36]

My care providers can learn from me - about my past, what I've gone through. I would be willing to share this knowledge with them. [CR8:31]

This may show that enhancing care receivers' awareness of their unique position as an expert-by-experience may contribute to 'amour de soi'. Motivating them to share this knowledge with care providers may have an even greater impact on perceived self-worth. This may be done through formal arrangements such as care receiver inclusion in care provider training and in service development strategies.

The knowledge need related to mindfulness may be accessed through various ways. Here I perceive the main aim as being that of guiding the care receiver to:

- 1). Be aware of why s/he is where s/he is at the present time
- 2). Explore the meaning that this experience has for him/her
- 3). Reflect on what s/he is getting, may get or wish to get out of the hospital and the different therapeutic alliances
- 4). Be actively aware of actions that s/he does or doesn't do and how these fit into his/her recovery and life plan

Reflexivity and spirituality may be useful in this regard:

But the way I behave - spiritually - I reflect...sometimes I like to stay alone and observe and reflect upon what other people need. This spirituality helps me to keep my relationships balanced. [CR3:38]

However, what may be even more useful is the provision of information related to the care receiver's symptoms, care plan, and the psychiatric system e.g. information about rights. These activities may be helpful in orienting the care receiver to the current situation and to add meaning to it:

I would like more information about my symptoms, the type of illness that I have, my drinking, my over spending. [CR2:11]

Patients need to have knowledge about their symptoms, about the treatment, why certain rules are there, their rationale, information about what is going on. [CR9:43]

Available resources such as the *Recovery Star Approach* may be useful to facilitate reflective activities as well as to enhance awareness about one's position in the recovery plan (See: Outcomes Star, 2009). Thus, for some care receivers, hospitalisation may hopefully start to mean much more than a place for refuge in that the hospital may actually start being perceived as having an active therapeutic potential. Perhaps enhancing mindfulness may also help in addressing the *Revolving Door Syndrome* – a phenomenon which has been identified in some healthcare settings such as the psychiatric hospital involved in this study (Vella, 2009).

Finally, the need for knowledge related to assertiveness may be addressed by the provision of care receiver training. This can be done on a one-to-one basis or during group work as facilitated by tools such as *DESC script* or *Interpersonal Skills ToolClicks* (Slade, 2009, p.19). Motivational interviewing may be another useful technique to initiate change towards an approach that is more assertive and targeted towards recovery (Slade, 2009, p.20). Furthermore, information about the current care plan, complementary/alternative recovery techniques to the medical model and legal rights may be useful in helping a care receiver to gain knowledge and communicate assertively.

Having explored the knowledge areas related to the theme of empowerment, I am now going to examine the new positions that the acquisition of this type of knowledge may offer to care receivers and providers. As I glance at the area of 'amour de soi', or self-worth, I realise that this may place the care receiver in a position where s/he acknowledges the fact that s/he is an expert – by experience and by virtue of being the care receiver and hence in a position of being the most knowledgeable entity in terms of what s/he is actually feeling. Subsequently, this makes him/her an important member within the alliance and gives him/her the right

as well as the duty to manage the knowledge-power balance in the therapeutic alliance.

On the other hand, acquisition of knowledge about mindfulness or awareness of the *here and now*, may give rise to a position where the care receiver is acutely aware of the purpose of his/her stay within the psychiatric hospital as well as the scope of each of the therapeutic alliances that s/he is part of. More importantly, this may allow the care receiver to link his/her current situation and experience to current and future plans.

The provision of knowledge about assertiveness may be seen as offering a care receiver position that complements the previous ones that have just been described. This may feature active involvement and positivity as brought about by a care receiver's acquired knowledge in relation of his/her self-worth ('amour de soi') and acute awareness of his/her current situation (mindfulness). The extra factor that may be added by assertiveness knowledge is the ability to act and communicate in a manner that has the potential to manage the knowledge-power balance in alliances in an effective manner that is targeted towards personal (as opposed to clinical) recovery.

On shifting to the collective positions that these three discourses may offer to the care provider, it can be noted that probably, the professional may find himself/herself in an alliance with a care receiver who is not a passive entity but who is willing to engage in a dialogue and to be an equal partner in care. This may be an attitude that the care provider may welcome, encourage, ignore or resist depending on the discourses that govern his/her professional approach, as described in Section 4.3 of this chapter.

## **Conclusion**

In this theme, I have explored three complementary areas of knowledge needs that I have perceived as constructing the overarching theme of empowerment. Care receivers' knowledge needs identified through the areas of 'amour de soi', mindfulness and assertiveness have been addressed and practical ways of guiding care receivers to acquire these knowledge-types have also been postulated. As discussed, it is felt that the provision of this knowledge may empower care receivers to manage the knowledge-power nexus in therapeutic alliances in a manner that is based on a recovery approach and that is likely to enhance therapeutic outcomes.

## **4.4.2 Potential knowledge that may be required by care providers**

### **Theme 1: Humanism**

#### **Introduction**

The theme of humanism emerged from some of the data that showed knowledge requirements in terms of a humane approach within the alliance. This features the need for some of the care providers to exhibit an attitude that places the care receiver at the forefront by actions that are targeted towards the individual's personal recovery.

#### **Discussion**

The knowledge needs that have been identified as falling underneath the theme of humanism have been constructed in a number of ways in the interview transcripts and in the professional records included. During certain instances, the data collected indicated that some care receivers may be feeling as if they are invisible and ignored by their care providers. This may show that the type of knowledge needed by some care providers was constructed as being based on regarding the care receiver as a person who has the capacity to think and feel:

My role in the multidisciplinary team is to dread each ward round because it means a change in medication. I do not have any importance within this team. [CR4:21]

I feel as if I am not treated as a person. I wish that they would speak TO ME. Explain TO ME...to treat me like an intelligent human being, which I think I am. [CR9:21]

At times, the data showed that some care providers may require knowledge in terms of addressing the care receiver as an equal partner within the alliance. In this manner, the knowledge required was constructed as being related to the need for care receiver inclusion and involvement in care - a collaborative approach:

I did not know that he (*the psychiatrist*) had increased my pills because he informed the Nursing Officer only. [CR2:26]

I am not satisfied. I wish that before they prescribe medicine, they ask the patient whether he wants it or not. And the patient has every right...the patient can decide what type of treatment he wants to have and the doctor has to co-operate with him not just force him to take medication. [CR4:30]

Finally, care provider knowledge-needs were also constructed as the requirement to learn how to offer a range of care options instead of restricting treatment to the biomedical model, in particular psychiatric admission and psychiatric drugs:

I was not offered any other options apart from admissions. [CR6:7]

I did not have any choices about treatment. No one offered me any choices. [CR1:34]

The constructions that have been discussed in relation to the theme of humanism may be seen as falling within the remit of two knowledge areas that may be required by care providers in the study. The first one that has been identified is knowledge related to **behaving in a civil manner**. Gergen (2001) described this as the act of learning how to show respect for others (p.71). In the context of this discussion, this refers to the need for some care providers to enhance their knowledge of how to treat care receivers in a manner that is more civilised, as indicated by Care Receiver 6:

The nurses need to be educated - basic education about how to interact with people, people who are at our level, who suffer from depression...patients do not speak because nurses snap at them and that destroys all the trust. They (*the nurses*) need to speak to you not tell you the contrary. [CR6:35]

For some care receivers, this may necessitate the provision of options and choices (rather than impositions) as well as active involvement in care planning:

I was not involved in the care plan. Actually, he just changed my pills without informing me about it. I wish that I'm involved. Because they think that you do not know how to do anything. [CR1:32]

Professionals need to know how to deal with care receivers: to advise but not impose. [CR5:36]

The second knowledge need identified centered on the area of **mindfulness**. This describes some of the care providers' possible need to acquire knowledge on how to focus attention on the present moment (Black, 2011, p.1). In this context, this refers to more awareness of the implications of what one says and does especially in terms of its potential impact on care receivers. In particular, this relates to words and actions that may be used automatically without much consideration of their effect:

When I ask the professionals about what is wrong with me, they answer: "That's life." [CR5:14]

Sometimes I do ask about why I am taking the pills and the answer is: "Because you need them". [CR2:20]

They (*the nurses*) are ok but I think that most of them are not really interested..you sort of realise when they speak to you..even the way they speak, the tone of voice. Like I am bothering them and they want me to leave them in peace. That is not nice, it makes me feel uncomfortable. [CR10:33]

Mindfulness has also been discussed in relation to the knowledge required by the care receivers. Whilst the same definition applies for both entities in the alliance, its manifestation is different – this shall be discussed in a later part within this theme. Each of these two required areas of knowledge shall now be explored in more detail.

In a summary of the main points that emerged from excerpts that highlight the need for knowledge related to civil behaviour, it seems as if some care providers may require knowledge in relation to the following areas:

1). Perception of the care receiver as a person who may require information and different care options to choose from rather than imposition of treatment types:

I tell the professionals that I am not happy and they answer that I should go to another ward - you go to another ward which is worse than this one. [CR1:42]

But they do not talk a lot in front of you. First they decide and then they ask you to enter the ward round room. Sometimes my parents go in alone and then they let me in afterwards. [CR1:45]



My psychiatrist does not give me enough information on my symptoms. Now just because this morning he told me : “We’re not going to do the ECT and we’re going to stay without the pills and you need to make an effort.” TELL ME WHAT I HAVE! No, I did not ask him what am I suffering from - what I have. [CR9:10]

At the moment, I have a nurse who is with me all the time because I told them that I wish to die. Sometimes I would not even know who the nurse allocated to me is. They do not let you know, they do not say anything. Then I realise who it is because this nurse keeps following me. [CR1:58]

2). Recognition that a particular care receiver is different than other care receivers hence respect for a person’s uniqueness needs to be demonstrated:

One: Speak to me not just to my husband as if I do not have any worth. Two: Explain to me. You have to be intelligent enough to understand how much I can understand. Because not everyone understands in the same way and at the same level. I am not better than anyone else, do not get me wrong please. But if I am able to understand and I would like to have more knowledge and I can understand, explain to me then. In their training, they need to have an experienced trainer who will demonstrate how to do this. But at the end of the day, it is a question of personality. After they are shown how to, some will do it, others will not. Because some think that they reach god-like status when they qualify. [CR9:42]

3). The therapeutic milieu and the therapeutic alliance are not automatic happenings and need to be shaped in order to enhance a care receiver’s recovery. Moreover, the alliance is a very important building block for therapeutic outcomes and so it needs to be exploited:

Now the way the doctors are behaving, they are being carnivorous. Why are they being carnivorous? Because they said that they will treat me first and then I will get married. They lied. [CR4:9]

Professionals, especially the doctor, need to know how to co-operate. [CR4:35]

4). The care provider’s behaviour in the context of the alliance may influence not only the management of the knowledge and power balance but also the overall effectiveness of the same alliance and the care provided. Hence the way one speaks to and about the care receiver as well as the way in which one writes about the care

receiver may be imperative in the management of the knowledge-power balance in care:

You need to go down to their (*the patients'*) level and make the time to speak to them, even if it is just for 30 minutes. You inform the patient that you only have 30 minutes. And that is ok. As long as you explain. This is part of their work. And you cannot really tell a patient: "Hey at 11am, I have my break." They need to speak to the patients. As a patient, you cannot really change the nurses. But someone needs to speak to them (*the nurses*). Someone who manages them and tells them these things, patients need to speak. [CR6:34-35]

5. The acknowledgement that there may be a difference between what the care receiver means and the care provider's interpretation. The overuse of medical jargon, automatic wording and clinical formality may widen the gap between the care receiver's meaning and the re-constructed understanding:

Serenace is a treatment used for the voice...that is what the doctor said. He said: "It is 'Serenace' by Claudio Villa!" The song 'Serenata' by the singer Claudio Villa. He did not give me any other information so I assumed that it is used for the voice. And so I started to sing during the ward round. [CR2:22]

Medical officer of firm.

Patient reviewed. History noted.

Wants to go home for a weekend.

Currently slightly elated and overtalkative.

Suspicion of possible alcohol use if leaves.

In this instance, only permission for Main Garden accompanied. To review permission in next ward round. [MR2:E3]

They do not tell me anything about my symptoms. They write in Greek or Latin and I do not understand. [CR2:9]

When they are talking directly to me, I understand what they are saying obviously. But sometimes when the doctor talks to the young doctor or even to the nurse or social worker..it changes. The manner of the doctor changes..he speaks in a different way and uses a different language..like a lot of medical words that I do not understand. Sometimes this irritates me because this is ME that they are talking about so why cannot they keep it simple? [CR10:26]

When I enter the room and sit in front of the doctor and all the other professionals, it makes me feel anxious and I forget most of what I would have wanted to say...the ward round is usually over in 10 minutes unless

there are any big problems. That is not enough for me to relax and start talking some sense. Especially if there are a lot of people in the room...the air is kind of heavy...then I do not feel very comfortable and just do what it takes to get it over and done with. [CR10:28-29]

The points that have been mentioned above are not a novelty finding that has emerged out of this study since major contributions to this area have been made by key figures like Carl Rogers, Peter Breggin and Hildegard Peplau (See: Breggin, Breggin & Bemak, 2001; Rogers, 1961 & Peplau, 1952). Thus the emergence of care provider knowledge needs in relation to civil behaviour is not surprising since the importance of a civil (and person-centered) approach has been addressed in detail by various theorists over the years. However what is surprising to me is the awareness that there may still be the need for this type of care provider knowledge in a civilised 21<sup>st</sup> century country. This finding is even more surprising when I realise that most likely, the professional training undertaken by the care providers who were included in the study had already included these areas within the training. This leads me to ask: *Why is this knowledge not being applied in practice by some of the care providers?*

This question has been partially answered in the discussion pertaining to the themes of The Pathological Lens and Depersonalisation in Section 4.3 of this chapter. In particular, I referred to time-management issues, staff shortage, burn-out, alienation, working on auto-pilot and attitude/ motivation problems as potential explanations for uncivil care provider behaviour. This highlights the need for future studies that explore these issues in detail especially with regards to the support (and knowledge) that care providers may need in order to enhance the quality of their professional life. It is felt that in view of these findings, the first step towards enhancing person-centeredness and an approach towards care that is more civil consists of an exploration of these issues. It may also be beneficial to explore how civility is taught in undergraduate courses. Russell (2014) described how in the literature, very few effective strategies have been proposed as to how to teach students to be civil and respectful in professional relationships (p.313). Perhaps it may be useful to strengthen the teaching structure in this area by applying a philosophical framework such as the use of virtue ethics as suggested and described by Russell (2014).

Basing therapeutic interactions on civil behaviour may give rise to a position within the therapeutic alliance that is characterised by respect for the care receiver's uniqueness as a person. It is felt that this may consequently lead to more effective management of the knowledge-power balance within the alliance since the care receiver may be viewed as being an expert-by-experience, a partial knower and a partner in care. In this manner, some care receivers may feel more valued and empowered which may in turn enhance therapeutic outcomes. At the same time, this may place the care providers in a position where the alliance is viewed in a more positive light, which may be a factor that contributes to professional satisfaction as found in a review carried out by Hayes, Booner and Pryor (2010, p.808).

The second type of knowledge need that I have identified from the findings is related to mindfulness. As stated earlier, this refers to some of the care providers' potential need to acquire knowledge on how to focus attention on the actions being carried out at the present moment. Importantly, this refers to reflection on the rationale for these actions as well as potential consequences on self and others.

A review of the interview transcripts shows examples of instances where care providers may be engaged in mindless practice or behaviour that can be described as *automatic* - as if they are on auto-pilot. An example of this is the plethora of automatic wording that has been encountered in some of the records - this was discussed in further detail in Section 4.3 of this chapter:

Day report: Comfortable day. Level 1 supervision not covered. Treatment as per chart.

Night report: Comfortable night. Treatment given as per chart: Level 1 covered by Nurse X. [NR1:13-14]

Day report: Comfortable day.

Night report: Comfortable night. Treatment given as per chart. [NR2:24-25]

Day report: House chores done. Treatment given as prescribed.

Night report: Good night. Treatment given as per list. Took part in pm chores. [NR5:2-3]

Remains slightly elated, overtalkative with paranoid ideation

Denies suicidal wishes, Thoughts of revenge/ harming others

Coping well on ward

No problems. [MR2:E2]

Similarly, some care receivers have described situations which suggest that they may have been subjected to a care provider attitude that lacks mindfulness:

I told him that the pills are tiring me and I am oversleeping. His response was to add other pills. I had started to joke around with him and he said that I am high and that is why he prescribed more pills. [CR2:26]

I try to speak to the doctor about it but he ignores me. He does not wish to speak to me. Nothing. He does not pay attention. [CR4:16]

The doctor that I had before used to tell me that the psychiatric hospital would harm me... He used to tell me - that place would harm you because the reputation spreads round very quickly and that will not be beneficial for your workplace. So he always discouraged me from going there. [CR9:8]

The reasons for an approach that lacks mindfulness may echo the same reasons that have been identified earlier as possible causes for lack of a civil approach and so I reiterate my earlier recommendation for research that focuses on causation and deeper exploration of these issues. It is felt that this lack of knowledge about mindfulness may be one of the factors that may lead to alliances such as the *Resentment-Opposition* type identified by some of the participants as well as to the discursive theme of Depersonalisation that emerged from some of the medical and nursing records, as discussed in Section 4.3. During an interview with Dreyfus and Rabinow (1982), Foucault may have referred to this when he alluded that: “People know what they do; frequently they know why they do what they do; but what they don't know is what what they do does” (p.187).

Hence, applying Foucault's assertion to the therapeutic alliance, it may be the case that some care providers may not realise what mindlessness can do to the alliance and the care receiver in it. For example, in the latter excerpt that has been presented, the care receiver described how her previous doctor used to warn her that the psychiatric hospital may harm her due to the stigma involved in being hospitalised – one may wonder whether there had been any consideration on the implications that this may have if the care receiver in question would need to be admitted to this hospital. Furthermore, such statements by the doctor may contribute to stigma towards the psychiatric hospital and the care receivers in it. During the interview,

Care Receiver 5 may have provided another example of the need for knowledge about mindfulness:

When I am with the nurses, I feel quite ok. Not with all of them though. Mostly it is “Hello” and “Thank you” with the nurses. Sometimes I open up with them but they say: ‘You will get better. You have a husband who loves you and respects you. Be brave so that you get out of here.’ [CR5:31]

In this example, the nurses’ intention was probably based on benevolence and aimed to instil hope in the care receiver. However, on deeper analysis, a tone of patronisation and inaccurate assumptions may be detected – this was probably unintentional and due to mindless statements. For instance, in this excerpt, the care providers are described as having prompted the care receiver to be brave - the problem that I relate to this statement is that the degree of recovery and discharge from the hospital may be related to many other factors other than bravery. Thus I feel that the nurses’ assertion may easily and inaccurately imply that failure to recover may equate to cowardice on behalf of the care receiver. This identifies the need for care providers to have knowledge about the concept of mindfulness and its practical application to clinical practice. At this point, a difficulty that may arise is how to teach mindfulness in relation to humanism, if it can indeed be taught:

I am not sure if this is something that can be learnt during their studies. It is something that has got to do with the character of the nurse or the doctor. For example if the nurse or the doctor show that they are interested in what you are saying and do something about it..then that is good and the power is being used in a good way. That would be the ideal balance and you would feel comfortable. But isn’t that the personality of the doctor or the nurse? I do not know if that can be taught at university. [CR10:48]

Literature on mindfulness presents a range of techniques that may be useful in education such as training in reflexivity and meditation (Harvard Health Publications, 2013). I feel that these areas may be adapted for use in enhancing care provider’s knowledge in this area. Perhaps the knowledge required about mindfulness may also be incorporated in training related to the use of emotional intelligence. Mayer and Salovey (1997, p.10/11) defined emotional intelligence as the ability to:

- accurately perceive emotions in oneself and others
- use emotions to facilitate thinking
- understand emotional meanings
- manage emotions

I feel that this may bear resemblance to the need for mindfulness in practice since awareness about emotions and their ongoing assessment and management may prevent a care provider from entering into a state of auto-pilot.

As discussed in Chapter 2, the application of the concept of emotional intelligence to the therapeutic alliance has been elaborated by Poullis (2007) who noted that research on the subject may be lacking (p.5). Furthermore, he explored the competencies that may be needed by care providers in order to use emotions in an intelligent manner within the therapeutic alliance. The competencies identified are similar to those identified by Goleman (2005) and Bar-On (1997) and involve an array of intrapersonal skills (e.g. self-awareness, self-regulation, stress management, adaptability, the ability to manage heavy feelings and motivation) and interpersonal skills (e.g. empathy and social skills) (Poullis, 2007, p.110). Whilst I feel that these areas were probably a part of the training undergone by some of the care providers in my study, it could be that various factors in their professional life may have led to emotional blunting and so continuous professional development in this area may be required. The care receivers who participated in this study unearthed another valuable resource that may be useful for this purpose: eight out of the ten care receivers who were interviewed clearly stated that they are willing to share their knowledge with professionals in order to contribute to their understanding of experiences of individuals under their care:

The professionals can learn a lot from me - about medications, about human traits and behaviour. [CR4:33]

I think that professionals can learn from me and I would be happy to share my knowledge with them. [CR3:37]

I feel that this may also be fruitful in enhancing care provider mindfulness by enhancing awareness of the care receiver's experience and consequences especially

in relation to care outcomes. In local healthcare, uni- and multidisciplinary case conference reviews are a common teaching practice in hospital settings. Perhaps it may be beneficial to start including care receivers within these sessions – this time in the role of a teacher.

A number of positions may result if care provider knowledge about mindfulness is present in the alliance. For instance, it is possible that some care receivers may feel less invisible due to a mindful attitude from the care providers' side. This may also lead some care receivers to manage the knowledge-power balance in a more effective manner due to less passivity and/or anger in view of the fact that they are receiving their care provider's mindful attention. On the other hand, knowledge about mindfulness may place the care provider in a position where s/he is able to reflect on actions and to question their rationale. This may serve as an opportunity to evaluate practice and develop it accordingly. In addition, it may also lead to professional growth and may potentially add meaning to an otherwise boring professional life that may be characterised by automatic and routine tasks.

## **Conclusion**

In this theme, I have explored emerging knowledge needs related to the concept of humanism. Knowledge pertaining to civil behaviour and mindfulness were identified and I described how care provider training in areas related to mindfulness and emotional intelligence may be useful. In addressing civil behaviour, the need for care provider support was suggested since knowledge may not be the only lacking factor in this regard. The need for exploratory research was also recommended in view of the two main knowledge areas that were discussed in this theme.



## **Theme 2: A Tailor-Made Approach**

### **Introduction**

This theme concerns the type of knowledge that may be required by some care providers in relation to the need to embrace the concepts of individualism and diversity whilst building alliances with different care receivers.

### **Discussion**

Knowledge with regards to this overarching theme was constructed through several ways in the interview transcripts and the medical and nursing records. For instance, one construction that emerged from the data may present a possible need for knowledge about person-centered care rather than a *one-size-fits-all* perception:

I would like to have information that is more objective. And if I really do exhibit this cheeky behaviour and I am at fault, then explain it to me, give me further detail and tell me about what I am really doing wrong. Explain to me, don't just tell me: "You need to fight." Explain to me how I can fight this and what am I fighting against. [CR9:14]

Similarly, the data collected may indicate that care providers may require knowledge about the fact that care receivers vary from one another and these differences need to be addressed within each specific therapeutic alliance. For instance, this may refer to variations between care receivers in their understanding of the symptoms and the experience that they bring:

I am not sick or mental. Mental implies that you are weak. I do not have any symptoms. [CR4:7]

The symptoms that were listed in the online forum are a match with what I am feeling. That you lose interest in everything, even in things that you used to like. That is the main symptom. [CR1:21]

Additionally, care receivers may vary in their perception and acceptance of treatment:

I am satisfied with the treatment - I used to take a lot but now it is down to just two: two in the morning and two in the evening. Last week they took

another one off me - the one in the afternoon. At first I was shaking a bit but now I am getting used to it. [CR8:17]

Now the doctor had informed me that he can give me Viagra so that I can have an erection. But the problem is, and I discussed this with the psychiatrist, that Viagra is contraindicated for people who take medications for high blood pressure. I have been impotent for 20 years. [CR4:20]

Day report: Treatment given as prescribed. Seen by Dr.X. Doctor made note in file to increase Modecate to 150mg. Dr.X contacted and informed that the patient is refusing to take depot. Dr.X will contact Dr.Y for further instructions. [NR4:37]

On examination of the different constructions of the knowledge required by the care providers, I view the need of care provider knowledge related to **individualism** and **diversity**. Individualism refers to the knowledge that some care providers may need in order to pay attention to the fact that each care receiver has a sense of inner self with rich thoughts and feelings. This also includes recognition of the care receiver's perspectives, attuning to his/her needs, importance of his/her rights, fair treatment, and respect of his/her self-worth (Lyons & Coyle, 2007, p.124). In the findings that emerged from this study, the relation of individualism to the knowledge required by providers, features in the implication that an individualistic approach to the alliance and the care receiver may be fruitful in the management of the power balance. This highlights the need for an approach that features each alliance and the entities within it as unique and as being characterised by specific needs and knowledge-power balance. Care Receiver 7 may have referred to the need for this approach (and the knowledge related to it) when she referred to her perception that her own perspective and needs may not be getting acknowledged:

Right now, I need to be in an acute ward and not a rehabilitation one because it is dangerous keeping me here but they do not realise it. I am afraid that I may smash a few windows if they do not help me. The kind of help that I need is: I need to have a rest, I do not want to be with men. I just need to rest for a couple of days. Not see people, I do not want to see anyone. I want to have my cosmetics and my change of clothes and I am quite happy. I do not want to smoke cigarettes. I do not want to be involved with people. I want to have a good sleep. I don't want to eat too much. I want to get myself under control. I am in the wrong place here, it is not helping me. [CR7:7]

A documented clinical assessment that formed part of one of the medical reports in the study may have similarly portrayed the need for knowledge on how to place more importance on individualistic care receiver traits rather than sole focus on a description of pathological symptoms. As an example, the following excerpt on the mood/thought content assessment of the care receiver may be providing valuable pathological information but at the same time, it may be omitting the person's individualistic meaning and experience of the symptoms described:

Mood: Neutral mood - congruent affect

Thought content: No paranoia, no delusions

Feelings of hopelessness at times

No current thoughts of suicidality [MR9:45-48]

On the other hand, knowledge related to diversity refers to the need of care providers to learn how to address variations between care receivers. Whilst noting that this may overlap with knowledge on individualism, I perceive these two areas as being related in a consecutive manner. This is due to the fact that as discussed, an individualistic stance is aimed at identifying the unique characteristics of every person. Successively, an approach that acknowledges diversity is targeted at the ability to identify and distinguish the differences in these unique characteristics between care receivers. Care Receiver 3 may have identified the need for care provider knowledge in this aspect when he stated that:

Professionals need to learn that not everyone is the same...I think this nurse would learn a lot if he were to spend some one-to-one time with the patients. That will teach him that not all patients are the same. Because here they have different types of patients. And sometimes it seems as if all patients are the same. [CR3:39]

Similarly, Care Receiver 1 asserted that:

Professionals need to realise that everyone's mind is different. [CR1:73]

Perhaps the need for care provider knowledge about diversity also featured in the different care receiver approaches to recovery, as they emerged from the findings. For instance, the following excerpts depict diverse care receiver approaches in the quest to obtain information:

I got the knowledge from myself, sometimes I read about alcohol. [CR3:18]

I have checked about it on the internet and my symptoms form part of Borderline Personality Disorder. [CR1:21]

I never searched elsewhere for information. You start learning on your own. Like certain symptoms, or if a doctor comes to see me and prescribes a drug. And this drug does not agree with you and he sends you home. [CR6:11]

Similarly, when some care receivers discussed their coping mechanisms, important differences were noted:

I hear voices, you know. I have a row with them (*the voices*) and they go away. If I tell the doctor that I hear voices, he will just bong me up with more medication, he will give me a needle which I do not need. Luckily enough, I am not taking any needle. Sometimes I feel like a needle but I do not take a needle. I order the voices to go away. [CR7:9]

I write in my diary how I am feeling every day. [CR8:9]

Following the identification of these main knowledge areas, they shall now be explored in further detail. In an approach that addresses the two areas of individualism and diversity simultaneously, I am going to use Garner's Theory of Multiple Intelligences as the base of my argument. As discussed in Chapter 2, Gardner (1983) argued against the notion that there is only one type of intelligence by contending that apart from the form of intelligence that may be assessed by IQ testing, other areas or types of intelligence may also exist (p.xv). In view of this, he proposed nine abilities or intelligence subtypes, these being: *Musical–rhythmic and harmonic*, *Visual–spatial*, *Verbal–linguistic*, *Logical–mathematical*, *Bodily–kinaesthetic*, *Interpersonal*, *Intrapersonal*, *Naturalistic* and *Existential*. A review of the literature shows that Gardner's theory has been extensively applied to the discipline of education in terms of the employment of flexible teaching methods to address the multiple intelligence-types. Pearson (2011) discussed how this theory may hold promise for application to the therapeutic alliance albeit the paucity of research in this area (p.20). In fact, a literature search on the topic shows that the application of the Theory of Multiple Intelligences to therapy is practically restricted to the counselling of children and it still finding its way into adult counselling. Importantly, the use of the theory has been linked to favourable outcomes and in

terms of the therapeutic alliance, it may enhance flexibility and better representation of the care receiver's preferences (Pearson, 2011, p.1).

It may be that the knowledge needs identified in my study in relation to individualism and diversity may be an echo of Garner's view as well as Pearson's contentions in relation to the presence of multiple intelligences within therapeutic alliances. This is due to the fact that the need for individualism may be pointing towards an individualistic way of how each entity within the alliance acquires and manages knowledge whereas an approach that respects diversity complements this view by adding that there are variations in how these entities may do this. However, on reflecting upon the application of the Multiple Intelligences Theory to the therapeutic alliance, I feel that the word *intelligence* may not be an adequate or comprehensive representation with regards to issues related to individualism and diversity within therapeutic alliances. Subsequently, I am going to substitute Gardner's use of the word *intelligence* with *way of being*. Here I am contending that each entity in the therapeutic alliance has a particular *way of being*: an individualistic style that results not only from the person's intelligence/learning type but also from his/her cognitive style, personality type and overarching take or preference to viewing and living life as well as to perceiving experiences. Consequently, this way of being may be governing the person's perception of recovery and treatment modalities as framed within the alliance. In a similar manner to Gardner's multiple intelligences, there may be multiple ways of being and each individual may have one or more preferred modes. This culminates in the argument that since the goal of the therapeutic alliance is to facilitate a care receiver's personal recovery process, then the care provider may need to:

- 1). Have knowledge about multiple ways of being and how to identify them
- 2). Be aware of his/her own way/s of being
- 3). Acknowledge that the other member in the alliance may have a different way of being and that this may create conflict and a detrimental imbalance of knowledge and power within the alliance if not managed properly
- 4). Direct the alliance so that it is in tune with the care receiver's way of being

The question that may follow is: *How then would a care provider attempt to identify a care receiver's way of being?* A useful starting point may be to categorise ways of being under the same categories that Gardner has used to classify the different multiple intelligences. Gardner contended that if, for example, an individual's intelligence-type is logical-mathematical, then s/he may prefer a learning approach that requires numbers, reasoning and critical thinking. On a similar note, I am postulating that if a care receiver has a logical-mathematical way of being, this may imply that the person may have a tendency to live his/her life under an umbrella of reasoning, numbers and critical thinking and the care provider needs to identify this mode of being and center the therapeutic alliance on it. In reference to the identification of different types of intelligence in counselling, Pearson (2011) presented similar ideas and presented existing assessment tools for multiple intelligences that can be introduced in therapy (p.11). He also identified how a counsellor may use the resulting information to shape the therapeutic alliance and care:

*(Narrative therapy)* may be preferred by clients who think and learn through written and spoken words, and have the ability to memorise facts, fill in workbooks, respond to written tasks, and enjoy reading...the musical/rhythmic intelligence is ideal for clients who can recognise tonal patterns and environmental sounds, and who learn through rhyme, rhythm and repetition...*(clients who prefer)* bodily/kinaesthetic intelligence can learn through physical movement and body wisdom, and may have a sense of knowing through body memory (pp.6-7).

However, I believe that the identification of a person's way of being goes beyond the sole use of the same classification system that is used to identify multiple intelligences. This is because a comprehensive assessment that includes a personality assessment, a bio-psycho-social-spiritual history and the person's current preferences and plans for the future, may provide further valuable information about the person's way of being. Until this point, I have presented my perception of the need to identify the way of being of each entity within the alliance. Here I add that it may also be important to assess for *counter-ways of being*. This refers to ways of being that may repel an individual and which, if not identified, may act as a barrier within the therapeutic alliance. For instance, if the verbal-linguistic sub-type is identified as being a care receiver's counter-mode, then probably a therapeutic approach that is

based on reading, writing and narrative work may be met with resistance. Similarly, if a person is, by nature, slightly messy, it may not be realistic, or even fair, if the care provider attempts to impose strict orderliness and neatness within the therapeutic alliance and care plan.

Basing therapeutic interactions on a multiple ways of being approach, which has originated from the identified knowledge needs related to individualism and diversity, may give rise to important positions within the therapeutic alliance. It is felt that if the care receiver's way of being is identified accurately and the alliance is tuned accordingly to his/her preferences or natural tendencies, then this may act to empower him/her to manage the knowledge-power balance within the alliance more effectively. This is brought about by the fact that the act of adhering to a care receiver's way of being may be viewed as allowing him/her to undertake his/her recovery journey in familiar territory. For example, if a care receiver has a musical/rhythmic way of being and thus has particular sensitivity to music, then a therapeutic activity such a lyric analysis may be more familiar and hence more empowering to him/her than life-story work.

This highlights the possible need for care providers to be knowledgeable in the application of the Multiple Intelligences (or Ways of Being) Theory to use within the therapeutic alliance. In academic training this may feature as knowledge in relation to familiarity with the different ways of being, the ability to identify them and to use them in facilitating recovery, as explored in a comprehensive paper presented by Pearson (2012). This may place the care provider and receiver in a situation where they are both partial knowers – whilst the care provider may be empowered as s/he has the knowledge of applying the multiple ways of being approach, the care receiver may also be on an equal level since s/he is being guided to recover in familiar territory that is congruent with his/her natural living tendency.

## **Conclusion**

On a concluding note, the knowledge areas related to individualism and diversity have been categorised and discussed underneath this theme. An exploration of these two areas has evolved into the recommendation of a therapeutic alliance that features a *multiple ways of being* approach. Such an approach is based on Garner's Theory of Multiple Intelligences as well as Pearson's work on the application of this theory to the therapeutic alliance. This highlights the need for care provider knowledge on this approach as well as its potential use in managing the knowledge and power balance within the therapeutic alliance in a more effective manner.

### **4.4.3 Conclusion**

This part of the chapter was dedicated to the knowledge needs that some care receivers and providers may have in relation to the management of the knowledge-power balance in the therapeutic alliance. These needs were identified from the participants' direct or indirect references and have been perceived as being based on three main themes. The first theme discussed was related to those care receivers who may need knowledge about self-empowerment – this emerged from a requirement for knowledge about appreciation of self-worth, mindfulness and assertiveness. Recommendations for activities and resources which may be used for enhancing this knowledge have been identified. Examples include reflection, meditation, assertiveness training and tools such as the *Johari window* and the *Recovery Star*. Subsequently, the discussion evolved into the knowledge needs of care providers – here the discussion was led by the main themes of Humanism and a Tailor-Made Approach. The theme of Humanism was constructed by the need for care provider knowledge pertaining to civil behaviour and mindfulness – involving the act of being mindfully aware of words and actions in an effort to interact with care receivers in a manner that is more humane and person-centered. This was followed by the Tailor-Made Approach theme which depicted the knowledge needs with regards to individualism and diversity amongst care receivers. In relation to these two areas, recommendations for providing the care provider knowledge that may be required



included reflective practice, care receiver involvement in education and basing interactions within the therapeutic alliance on a Multiple Ways of Being model.

In view of the knowledge needs that have been discussed, I postulate that providing the knowledge required may be beneficial in the management of the knowledge-power balance within the alliance. This may enhance therapeutic outcomes by possibly contributing towards care receiver recovery and care provider job satisfaction.

## **4.5 Chapter conclusion**

The discussion and analysis of the findings that emerged from the two data sources in this study may have helped in enhancing the understanding of the knowledge - power balance in the therapeutic alliance in mental health services. Furthermore, this chapter may have been useful in placing the findings of this study within the context of the theoretical and empirical knowledge that can be found in literature on the topic.

Notably, I believe that since the medical and nursing records that were included pertained to the same care receivers who were interviewed in the first phase of the study, the data from the two different sources may have helped in enhancing understanding of each other's findings. In this manner, each source may have been useful in offering tentative explanations to counterpart findings from the other source. In fact, cross-reference between the two parts was often done and the findings arising from the two sources may be described as being quite complementary to each other. This may confirm the importance of the use of triangulation in the method of this study.

Before concluding, I would like to briefly discuss the findings of the study in relation to therapeutic outcomes. It would be erroneous to state that therapeutic outcomes have been investigated in this study – this is because the main aim of this research endeavour was to explore the different discourses, their effect on practice and potential knowledge needs. However, an important link between my findings and

therapeutic outcomes may have been identified. This is based on the awareness that various research efforts have already been dedicated to an exploration of care provider and care receiver characteristics that may enhance therapeutic outcomes in care. In my study, some of these characteristics described in the literature have also featured as factors that may be playing a role in making the knowledge-power balance as it is in each specific alliance. Thus, for example, factors such as the presence of equality, attention to care receiver individuality and active involvement in care have been identified in the literature as being factors associated with positive therapeutic outcomes (Moore, 2006; Sharpley, Jeffrey & McMahan, 2006, Sullivan, Skovholt, & Jennings, 2005). In my study, these same factors have been identified within the *Collaboration* alliance type. Contrastingly, some research has shown that factors such as care receiver exclusion, expectation of submission and a patronising attitude may be related to negative therapeutic outcomes (Fauth, Gates, Vinca, Boles & Hayes, 2007; McCarthy & Frieze, 1999) – similarly these are some of the same factors identified in the *Resentment-Opposition* alliance type in my study. In view of this, it can be tentatively suggested that different alliances, as distinguished by their different types of knowledge-power nexus, may be related to positive or negative therapeutic outcomes. This link may be quite visible and straightforward in alliance-types such as the *Collaboration* and the *Resentment-Opposition* but perhaps not quite so in the *Satisfaction-Acceptance* and the *Dissatisfaction-Compliance*. This is because most of the care receivers in the *Satisfaction-Acceptance* model seemed to be satisfied with the knowledge-power imbalance in the alliance as well as showing overall satisfaction with the alliance. Yet most of them exhibited a degree of compliance in the context of the alliance. On reverting to existing literature, it can be seen that while care receiver satisfaction within the alliance may be linked to positive therapeutic outcomes, compliance (as opposed to collaboration) may be less so (Bachelor, Laverdiere, Gamache & Bordeleau, 2007; McCarthy & Frieze, 1999). Thus it is not clear whether the *Satisfaction-Acceptance* alliance in my study may be linked to positive therapeutic outcomes despite the apparent care receiver satisfaction that featured in it. Similarly, most of the care receivers in the *Dissatisfaction-Compliance* alliance seemed to be quite compliant as well as satisfied with the knowledge-power imbalance in the alliance. However, in contrast to the *Satisfaction-Acceptance* alliance, this satisfaction did not necessarily lead to overall satisfaction

with the alliance. Once again, this leads to questions about the potential degree of effectiveness of this alliance type. Hence, the relationship between these two alliance-types and therapeutic outcomes needs further investigation.

# CONCLUSION

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## 5.1 Headlines of the study

As this thesis nears its conclusion, it may be useful to engage in a final reflective exercise by attempting to combine the main outcomes in a succinct summary. Thus I feel that the following issues are the ones which are at the forefront of the research that I have undertaken, and that may need to be considered in the application to practice in the setting explored:

- Equalisation of knowledge and power in the therapeutic alliance
- The need to include and emphasise the care receiver's voice
- The need to promote the therapeutic alliance in the light of the ordinary

On reflecting upon the first point, I am reminded of Zur's contention that little research has been carried out beyond the seemingly forgranted notion that therapeutic alliances are characterized by a power imbalance (Zur, 2009, p.163). In this regard, this study has provided useful information since those alliances classified underneath the *Collaboration* alliance-type were not perceived by most of the participants as having a power imbalance. However, all the other alliance-types seemed to be characterised by a power imbalance. Whilst acknowledging that my research study was not aiming to explore the direct link between different alliance types and therapeutic outcomes, it can be tentatively suggested that some of the characteristics found in the different types of alliances may also link that particular alliance to positive or negative therapeutic outcomes. In particular, the majority of the alliances that were characterised by a power imbalance were linked to care receiver anger, resistance, fear and covert institutionalisation. In relation to the psychiatric setting explored in this study, I feel that this calls for the need to re-think the construction of some of the alliances. This may be done in order to focus on a

knowledge-power balance – a situation where care receivers and providers behave as partial knowers, as discussed by Brown (2007, p.12).

The second point is particularly linked to my personal satisfaction in knowing that this study gave a voice to care receivers. During the data collection, I was pleased and surprised by the fact that some of the care receivers thanked me for listening and for providing the opportunity for them to speak. On further reflection, I realized that this may be highlighting the need for similar opportunities to be provided within the hospital setting that has been explored in this study. In this regard, I strongly feel that it is empirical to start including care receivers in seminars, care planning, the implementation of new acts (such as the new Mental Health Act which is currently being introduced in Malta) and the auditing of care. Here I emphasise that *inclusion* does not refer to simply asking care receivers to come forward - this may be challenging for a care receiver who is situated in a setting where custodial care and power imbalances are in play. Rather this may necessitate reaching out to care receivers and providing non-threatening opportunities for them to voice their opinion. Perhaps the one-to-one qualitative method employed in this research study may be a good example.

The final point culminates in the simple yet profound awareness that perhaps it may be more useful to view the therapeutic alliance as a rather ordinary relationship – indeed a template for other relationships that the care receiver may form during and after his/her recovery journey. This is a shift from a perception of the therapeutic alliance as a complex system that has to be technically manoeuvred by highly skilled professionals by the application of specific advanced skills. Instead it may be more beneficial to focus on building a civil humane relationship that is based on anything that may help a person during his/her recovery: this may be a mix of ordinary stuff and professional knowledge (as an ‘invited guest and not as an overarching paradigm’ – Higgins, 2008, p.11)

## **5.2 A review of the information generated in relation to the research questions**

At the beginning of this study, one research question and two sub-questions were posed. In this concluding part of the thesis, these questions are going to be reviewed again and discussed in terms of the knowledge that was attained during the study.

### **5.2.1 Discursive themes and the role of dominant discourses**

The first two questions that were addressed were:

**What is the nature of the combination of knowledge and power in therapeutic alliances in a mental health in-patient setting in Malta? (Main question)**

**What role do dominant discourses play in the positions occupied by care providers and care receivers in therapeutic alliances in a mental health in-patient setting in Malta? (Sub-question 1)**

The findings related to these two questions have been categorized underneath the discourses arising from the interview transcripts and those that emerged from the medical and nursing records included in the study. They have been summarised as follows.

#### **Care receivers**

The dominant discourses that were identified from the care receivers' transcripts have been classified underneath four main discursive themes. Furthermore each of these themes also acted as a classification system of the alliances based on the type of knowledge-power balance in each alliance, as described by respective dominant discourses.

The first theme and type of alliance identified was *Satisfaction-Acceptance*. This featured an alliance which may be characterized by a knowledge-power balance in

favour of the care provider. Most of the care receivers were satisfied with the imbalance and with the alliance. The majority were also seen to be compliant but at the same time they were also quite active in care by eagerly following professional guidance. The dominant discourses within this theme were those of **romantic discourse** and **compliance discourse**.

On the other hand, the *Dissatisfaction-Compliance* alliance-type features a care receiver who may be quite passive and dependent on his/her care providers. In a similar way to the first type of alliance discussed, this alliance may be characterized by a power imbalance in favour of the care provider. Most of the care receivers seemed satisfied with this power imbalance yet this satisfaction did not extend to general satisfaction with the alliance. The dominant discourses that emerged were **compliance discourse** and **discontentment discourse**.

The third theme and type of alliance, namely the *Resentment-Opposition*, featured most of the care receivers in it as being angry and irritated due to a knowledge-power imbalance in the alliance which they perceive as being detrimental to them. Hence this may be viewed as the care provider being commonly perceived as having full control of the alliance, much to the care receiver's resentment. In this regard, the dominant discourses were those of **anarchist discourse** and **discontentment discourse**.

The final theme and alliance type was that of *Collaboration*. This depicts the care provider and the care receiver as being on the same level with no significant knowledge-power imbalance in favour of one or the other. Contrastingly, both stakeholders may be seen as contributing to the alliance and collaborating to facilitate the recovery journey. This type of alliance may bear resemblance to the contentions of the *Recovery Model* and features most of the care receivers in it as being satisfied with the knowledge-power balance and with the alliance. The dominant discourses were those of **assertiveness** and **equality**.

As already alluded to in Chapter 4, in practice, these alliance-types may feature as being on a continuum rather than being clearly distinguishable as they may have

been in the theoretical description offered in this thesis. One may argue that the care receiver's personality and pathology may have determined his/her perception of the knowledge-power balance in the therapeutic alliance. Whilst acknowledging this possibility, it has to be noted that the potential effect of these factors may not have really affected the care receivers' perception to a large extent. This is due to the fact that each care receiver was able to delineate clear differences amongst the multiple alliances that s/he was a part of. Hence each care receiver in this study was part of several alliances, each of which was associated with one of the four different types or themes, according to my interpretation.

### **Care providers**

The dominant discourses that emerged from the Medical and Nursing Records were also categorized underneath discursive themes. Three discursive themes were perceived as being constructed, namely the Pathological Lens, Depersonalization and Humanistic themes.

The *Pathological Lens* theme featured some of the care providers who wrote about the care receiver and the interactions within the therapeutic alliance in a way that tended to be clinical and shaped by the Medical Model. This was likened to a metamorphosis where most of what the care receiver did and said was then restructured to fit a pathological understanding. In particular, this refers to the overuse of medical jargon and to a phenomenon which I termed as *automatic wording*. The latter refers to words that feature with a high frequency in the records reviewed and that may be a result of professional *auto-piloting* – such terms include “comfortable day/night” and “treatment given as per chart” – terms that may not really be providing any valuable information about the alliance or care receiver. The dominant discourses in this theme were: **authoritarian**, **conservatist** and **pathological**.

The theme of *Depersonalisation* described those professional texts which tended to remove the person out of the patient. This may have resulted in a care provider's perception that s/he has an alliance with a *non-person*, with all the negative



consequences that this may have brought about. For instance, it could be noted that the words written by some of the professionals did not provide any information that indicates that the patient being described is in fact a person and not an object. The lack of use of the person's name in the records was also observed with most of the professionals opting to use the word *patient* or use of the third person instead of the person's actual name. **Minimalistic** and **depersonalising discourses** were the dominant discourses in this theme.

The final theme of *Humanism* involved those discourses that to an extent seem to be describing an alliance that is based on a somewhat holistic and person-centered approach. This shows a degree of importance being given to the use of the care receiver's name and his/her words rather than attempting to restructure the whole rapport. In this manner, collaboration rather than compliance may be the guiding model for interactions within the alliance. The dominant discourses in this theme were those of **equality, humanistic** and **recovery discourses**.

Although definite correlations cannot be made, it can be tentatively suggested that the two sources in the study may have complemented each other in describing the knowledge-power balance in the therapeutic alliances in the study. For instance, the professional theme of depersonalization may shed light on alliances such as the *Resentment-Opposition* type. Similarly the professional theme of humanism may be related to alliances such as the *Collaboration* alliance-type.

### **5.2.2 Knowledge required by care providers and care receivers**

The last sub-question leading this study was:

**What type of knowledge is required by care providers and care receivers for power to be managed in a manner that may enhance therapeutic effects in this setting? (Sub-question 2)**

In the analysis section, this research question was addressed by exploring that separate and specific knowledge that may be required by care receivers and other knowledge that may be required by care providers. The knowledge types that may be required by the care receivers were incorporated in one overarching theme, namely the theme of *Empowerment*. On the other hand, two themes led the discussion pertaining to the knowledge that may be required by care providers. The first theme that was discussed was that of *Humanism*. The second theme that was presented was that of *Humanism* followed by the final theme: *A Tailor-Made Approach*.

In the literature, there are several techniques that may be useful in addressing the different types of knowledge that may be required – in fact some of these were included in the analysis section. However, here I re-iterate the crucial need to view these skills and techniques as **examples and options** that may be **occasionally** applied to **some** therapeutic alliances. The emphasised words in the previous sentence are intended to highlight the risk of alternatively viewing my recommendations as prescriptive – ‘grand narratives’ (Timimi, 2013) or new dogmas of care that have to be applied religiously and routinely. If this were the case, it would indeed be a poor outcome of this study since it would probably simply instigate the repetition of more of the same – the replacement of the medical model with yet another framework that may be applicable and beneficial to some but most definitely not across different situations and cultures. Instead I am recommending that it may be more useful for care receivers and care providers to become familiar with different options and approaches that have worked for others and explore their application throughout the recovery journey. Timimi (2013) described this concept as a tool box which (during professional and personal endeavours/ experiences) gradually becomes filled with mainstream, alternative and complementary skills/ frameworks that one may pick up and use according to the circumstance.

### **5.3 Strengths, limitations and final words**

As described in Chapter 3, several measures have been taken in an attempt to enhance the trustworthiness of this study. However, I acknowledge that some

limitations were present. The major limitation could have been related to my familiarity with the research setting which may have affected the interviewee's responses. Luckily, I had never been in a therapeutic alliance with any of the care receivers that participated in the study so this may have limited this effect. Furthermore, my own beliefs have inevitably shaped my interpretation of the findings despite the measures taken to limit the extent of this possible bias. Despite the usefulness of an interview technique, this was associated with a lack of care receiver anonymity which could have also affected the findings. I feel that the document analysis of the medical and nursing records was an important and insightful part of the research. The limitation with the use of this technique was that since there was no direct interaction with the care providers themselves, no explanations about the written words could be given. In view of the concerns that resulted from the analysis of these records, there is a need for further research including interviews with care providers and observational techniques.

Although the aim of my study was to explore the knowledge-power nexus in the therapeutic alliance, I realise that at times, especially during the analysis and discussion, it also served as a clinical appraisal. Having unintentionally undertaken this appraisal exercise as part of my study, I feel that I can recommend the inclusion of care receivers and professional records in actual clinical appraisals in the local setting as these sources hold valuable clues to the quality of care being offered. On the same note, I believe that this thesis needs to be considered not only with regards to implications for education and the curriculum but also to the need of a new form of professional practice in the setting where the study took place. In fact, the participants in this study have explained what this new practice should consist of.

As a conclusion, I cannot help but to remember how intrigued I was by the valuable information that the care receivers shared with me during the interviews. Their insight and articulation of thoughts are a real find. Foucault (1990/1978) stated that "power is everywhere...because it comes from everywhere" (p.93). I feel that the therapeutic alliances that I have explored in this study are a reflection of this statement. This is because whilst it was obvious that a lot of power was coming from the care providers, I feel that my research has exposed another incredible source of power and raw knowledge - this emerged from the care receivers. Fortunately, these

care receivers have stated that they are willing to share this knowledge with their care providers. They just need to be given the opportunity to do so.

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## APPENDICES

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### Appendix 1: Guide for semi-structured interview: English version

The majority of the questions within this guide have been linked to each of the research questions, as depicted in table 1. However some of the questions are targeted at eliciting background information in order to enhance the individuals' narrative and allow for better understanding of the area under study.

**Table 1: Link between research questions and interview guide questions**

<b>Research question</b>	<b>Code</b>
What is the nature of the combination of knowledge and power in therapeutic alliances in an in-patient mental health setting in Malta?	<b>A</b>
What role do dominant discourses play in the positions occupied by care providers and care receivers in therapeutic alliances in an in-patient mental health setting in Malta?	<b>B</b>
What type of knowledge is required by care providers and care receivers for power to be managed in a manner that enhances therapeutic effects in this setting?	<b>C</b>

Please describe the events that led to your first contact with mental health services.

*(Intro. and background)*

Did you decide that you needed psychiatric help or was this decided by someone else? *(Intro. and background)*

If this was decided by someone else: *(Intro. and background)*

- How did you feel?
- What did you think?

- How were you informed – what did they tell you?

Did you choose the type of mental health service? e.g. admission to psychiatric hospital, psychiatric outpatients appointment or community services (*Intro. and background*)

On which basis did you make this choice? (*C*)

If someone else made the choice for you, did you agree with this decision? (*A, B*)

What do you know about your symptoms? (*C*)

Where did you get this knowledge from? (*C*)

What kind of information regarding your symptoms have you been given by the professionals that you have been involved with in the hospital? (*C*)

Do you feel as if you know enough about your symptoms? (*A, C*)

If not, what kind of knowledge do you think you need? (*C*)

What is the plan for your care? (*C*)

How was this plan formed? (*B*)

Were you involved in the formation of this plan? (*B*)

If not, did you wish to be involved? Why? (*A, B*)

What treatment are you receiving? (Here referring to psychological, complementary & alternative or pharmacological interventions) (*C*)

Have you been provided with available treatment options? (*B, C*)

How is the final choice of treatment done? (**B**)

What information were you given about the treatment from the person who prescribed it? (**B, C**)

Are you satisfied with your treatment? (**Background**)

If you were ever unsatisfied, what would you do? Why would you do this? (**A, B, C**)

How easy is it for you to understand the meaning of the language of your care providers? (**A, C**)

Describe your perception of your role within the multidisciplinary team. (Or: What is your role in the team of professionals who you have a working relationship with?) (**A, B**)

What influences the way that you perceive your role in this team? (**A**)

What are the professions of the psychiatric care-providers that you have a working relationship with? (emphasis on no need to mention actual name) (**Background**)

How do you feel when you are with \_\_\_\_\_ (to fill in blank with each professional type consecutively e.g. *with your psychologist*) (**A, B**)

Describe what happens in a typical session with \_\_\_\_\_ (to fill in blank with each professional type consecutively) (**A + background**)

What happens/ think would happen, if /when you give feedback and suggestions to \_\_\_\_\_ (to fill in blank with each professional consecutively) regarding your treatment and care plan? (**B**)

Do you feel as if you have less, equal or more power / say in your relationship with \_\_\_\_\_ (to fill in blank with each professional consecutively) (**B**)

Are you satisfied with the balance of power in your relationship with \_\_\_\_\_ (to fill in blank with each professional consecutively) **(A, B)**  
Why? **(A, B)**

If not, what would you change? **(C)**

What do you think are the factors that make this power balance as it is? **(A)**

In general, do you feel as if your suggestions and feedback are considered and used to change your care plan if necessary? **(B)**

You are the expert of your own care. What do you think about this? (Or: Do you see yourself as having knowledge about your response to the symptoms and then using this knowledge to work with your care providers? **(A, B, C)**

Do you think that your care providers can learn from you? **(A, B, C)**

If yes, what type of knowledge do they need to obtain from you? **(A, B, C)**

Do you think that your care providers wish to learn from you? How do you know this? **(A, B, C)**

How comfortable would you feel in sharing your knowledge with \_\_\_\_\_ (to fill in blank with each professional type consecutively?) **(A, B)**

What kind of knowledge do you think a care receiver needs in order to be able to manage power effectively with a care provider in a professional relationship? **(C)**

What kind of support do you think a care receiver needs in order to be able to manage power effectively with a care provider in a professional relationship? **(C)**

What kind of knowledge do you think a care provider needs in order to be able to manage power effectively with a care receiver in a professional relationship? **(C)**

What kind of support do you think a care provider needs in order to be able to manage power effectively with a care receiver in a professional relationship? (C)

## Appendix 2: Ethical approval

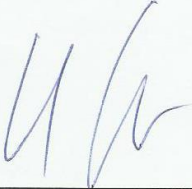
### (i). University of Malta Ethics Committee

*To be completed by Faculty Research Ethics Committee*

We have examined the above proposal and advise

**Acceptance**                      **Refusal**                      **Conditional acceptance**

For the following reason/s:

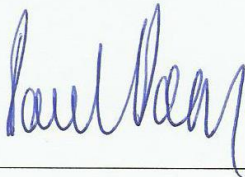
Signature  Date 14/11/2012

*To be completed by University Research Ethics Committee*

We have examined the above proposal and grant

**Acceptance**                      **Refusal**                      **Conditional acceptance**

For the following reason/s:

Signature  Date 18/12/12

**(ii). University of Sheffield Ethics Review Panel**

Paulann Spiteri

Head of School  
Professor Cathy Nutbrown  
Department of Educational Studies  
388 Glossop Road  
Sheffield  
S10 2JA

**Telephone:** +44 (0114) 222 8185  
**Fax:** +44 (0114) 222 8105  
**Email:** D.Goodley@sheffield.ac.uk

Dear Paulann,

**ETHICAL APPROVAL LETTER**

We are happy to accept the ethical clearance for your research project that you have gained from the University of Malta as required documentation for our Ethical checks in the School of Education. Please feel free to begin your empirical work.

If you do make any substantive changes to the fieldwork please can you contact me to inform of these changes

Good luck with your research.

Yours sincerely



Dr Dan Goodley

**Chair of the School of Education Ethics Review Panel**

cc Tom Billington



### (iii). Care Receivers' Consent Form

**Consent Form: *The Therapeutic Alliance in Mental Health Services: A Foucauldian Discourse Analysis***

Dear Sir/ Madam,

I am following a PhD in Education which involves the undertaking of a research study. My chosen study is: ***The Therapeutic Alliance in Mental Health Services: A Foucauldian Discourse Analysis***. You have been identified as a potential participant for this study. Please note the following points regarding the study:

- Participation involves one interview which lasts for 45-60 minutes and which will be carried out at a place of your preference.
- With your permission, I would like to audio record these interviews as well as to write down notes during the interview. This makes it easier for me to record information.
- With your permission, I would like to access the notes that doctors and nurses write about you in order to explore what is written about the relationships that you have with your health carers. These notes are found in the medical and nursing records.
- Your participation is voluntary and you are free to withdraw from the study at any time, without providing a reason. Withdrawing from the study will not have any effect on the quality of care that you are being given.
- No one but myself shall have access to the information so that anything that is said during the interviews remains strictly confidential.
- Your identity will not be revealed in the study report as pseudonyms will be used instead of names.
- Audio-recordings and transcriptions shall be stored securely and password protected. They shall be destroyed on successful completion of the study.

I have read and understood the information given to me about the research study. I hereby, give my consent for participation in the study.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_


Date: \_\_\_\_\_

To the best of the researcher's knowledge, the interview questions should not evoke harmful emotions. However, if following the interview, psychological assistance is required, this shall be offered by Dr. Michael Galea who can be contacted on 99262452 or [mgalea00@yahoo.com](mailto:mgalea00@yahoo.com)

Any queries regarding the study can be discussed by contacting Paulann Spiteri on 2340 1180 or 79730509 and [paulann.spiteri@um.edu.mt](mailto:paulann.spiteri@um.edu.mt) or her supervisor at [T.Billington@sheffield.ac.uk](mailto:T.Billington@sheffield.ac.uk)

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Paulann Spiteri



Professor Tom Billington

## **Appendix 3: Care receivers' primary and secondary analysis**

### **(i). Primary codes**

The primary thematic coding process of the interview transcripts led to the identification of fifty nine codes, each of which described the data related to it in a particular way. In this manner, some of the codes were directly related to specific knowledge/power themes in the data (e.g. Code: Dissatisfaction with power-balance type in alliance). In contrast, other codes that emerged described the data in a non-specific manner (e.g. Code: Interaction with the Nurses). The following list presents the primary codes and their definition:

#### **Ability to understand professionals**

A care receiver's ability to understand the language and the meaning of communication by care providers.

#### **Acceptance**

A care receiver's behaviour that shows him/her accepting to do what professionals say because s/he accept and agree with what is being said.

#### **Active involvement in care**

A care receiver's perception of being directly involved by professionals in his/her care

#### **Anger**

Expression or implication of feeling angry.

#### **Assertive behaviour**

A care receiver's ability to speak up for himself/herself and to behave in a goal-oriented way that is not aggressive.

#### **Boundaries in alliance**

A care receiver's perception or perception of influences of/on boundaries with care providers.

**Care/treatment choice offered**

The experience of being provided with care/treatment options and/or the type of options that were offered.

**Compliance**

Care receiver behaviour that shows him/her doing what others say without questioning and irrelevant of whether s/he agree or disagree with what is being said.

**Defensive care**

Perceived subjection of a care receiver to that type of care that is mainly aimed at safeguarding safety and tradition rather than promoting recovery and independence.

**Depersonalisation**

The act of removing a care receiver's identity.

**Determination**

A care receiver's intent to stick to plan by knowing what s/he wants and doing his/her utmost to get it.

**Disagreement with professionals/care plan**

A care receiver's thoughts/actions that imply that s/he does not agree with professionals or with the care plan.

**Discomfort**

A care receiver's reported feeling in a particular situation which is not emotionally comfortable for the individual.

**Discreditation**

A care provider's attitude that devalues a care receiver's opinion.

**Displeasure**

A care receiver's perception of not being pleased with aspects of care/treatment.

**Dissatisfaction with power-balance type in alliance**

A care receiver's implied or stated dissatisfaction with the power-balance type in a particular alliance.

**Events leading to hospitalisation**

A description of events that led to a care receiver's admission to the psychiatric hospital.

**Exclusion**

A situation which portrays the care receiver as not being included in decisions/care.

**Experience of symptoms**

The narrated experience of a care receiver's symptoms related to mental illness.

**Expression of trust in professionals**

Stated or implied trust by care receivers in care providers.

**Fear**

An emotion felt by care receivers in relation to the consequences of their actions and the feared care providers' reaction.

**Feeling misunderstood by professionals**

The feeling that was described by care receivers when they perceived themselves as being misunderstood by professionals.

**Hopelessness**

A care receiver who loses hope in himself/herself and recovery.

**Information required**

Information that was seen or implied as being required by care receivers.

**Information seeking**

The act of care receivers seeking for information about treatment, care or symptoms.

**Interaction with nurses**

Care receiver descriptions of interactions with the nurses.

**Interaction with occupational therapists**

Care receiver descriptions of interactions with the occupational therapists.

**Interaction with other professionals**

Care receiver descriptions of interactions with other professionals apart from nurses, occupational therapists, social workers, psychologists and psychiatrists.

**Interaction with psychiatrist**

Care receiver descriptions of interactions with his/her psychiatrist.

**Interaction with psychologist**

Care receiver descriptions of interactions with his/her psychologist.

**Interaction with social worker**

Care receiver descriptions of interactions with his/her social worker.

**Intermediate compliance**

The act of a care receiver who is being compliant as an intermediate step to an identified goal.

**Involuntary decision**

A decision that was taken against a care receiver's will.

**Involvement in care**

A care receiver's perception of being involved in care.

**Knowledge about care plan**

A care receiver's knowledge about his/her care plan.

**Knowledge about medication/treatment**

A care receiver's knowledge about his/her medication/treatment.

**Knowledge about symptoms**

A care receiver's knowledge about his/her symptoms.

**Lack of information-giving**

Care receivers' perception of a lack of information being given by professionals.

**Patronisation/Paternalism**

The action of talking/looking down on someone and to treat him/her as childlike

or inferior.

**Perception of additional/alternative treatment required**

A care receiver's perception of that additional/alternative treatment required to facilitate recovery.

**Perception of knowledge and support required by care providers and care receivers**

A care receiver's perception of the knowledge and support required to manage knowledge-power in the therapeutic alliance in a way that enhances therapeutic outcomes.

**Perception of mental illness and of the psychiatric hospital**

A care receiver's views on the concept of mental illness and the psychiatric setting.

**Perceived power balance in the alliance**

An identified or implied power-balance in a therapeutic alliance.

**Perceived power imbalance in the alliance**

An identified or implied power imbalance in a therapeutic alliance.

**Perceived reasons for power-balance type in alliance**

A care receiver's perception of the reason of the type of power-balance interface in a particular alliance.

**Perceived side effects of medication**

Side effects of medication as identified by the care receiver.

**Perceived subjection to expected submission**

A care receiver who perceives that s/he is being expected (by care providers) to follow and obey orders and decisions irrelevant of his/her opinion.

**Readiness to address disagreement/ give feedback**

A care receiver's readiness to show and convey disagreement with any issue in care and to give feedback to care providers.

**Reference to Traditional Medical Hierarchy**

References to traditional ranking of professionals according to the medical model

with the doctor on top of the hierarchy and the others in the levels below.

**Resistance**

A care receiver's resistance to aspects of care or to a particular care provider.

**Reported information given by professionals**

Care receivers' report of the information that was given to them by their care providers in relation to admission, treatment and the care plan.

**Reported language used by professionals**

Care receivers' description of language used by their care providers.

**Satisfaction**

A care receiver's implied or stated overall satisfaction with care.

**Satisfaction with balance of power in alliance**

A care receiver's implied/stated satisfaction with the power-balance type in a particular alliance.

**Self-perception of one's knowledge**

A care receiver's perception about his/her own knowledge about symptoms, medication, care and recovery.

**Sense of competing**

Implied/visible sense of competition between parties in a therapeutic alliance.

**Sharing of patient knowledge**

Perceived readiness of professionals to learn from care receivers and the care receivers' readiness to share their knowledge.

**Treatment/care perceived as being effective**

A care receiver's perception of the effectiveness of treatment/care.

**Treatment/care perceived as being ineffective**

A care receiver's perception of the effectiveness of treatment/care.

## **(ii). Worked examples of primary and secondary analysis**

In the following page, Figure 14 shows some excerpts that describe Care Receiver 5's alliance with the social worker. The excerpts have been coded during the primary analysis process using *Atlas.ti*.

When all the transcripts had been coded, secondary analysis was undertaken during which data was compared and patterns could be identified. This led to the grouping of the alliances into the four discursive themes/ alliance types that were described in Chapter 4:

*Satisfaction-Acceptance*  
*Dissatisfaction-Compliance*  
*Resentment-Opposition*  
*Collaboration*

For instance, Care Receiver 5's alliance with the social worker was one of the alliances that gave rise to the *Satisfaction-Acceptance* alliance type/discursive theme. As discussed in Chapter 4, this alliance type can be briefly described as:

*an alliance where the care receiver perceives the professional as being the entity in the lead and of creating a power imbalance within the alliance. Most of the participants appear to be satisfied with the alliance and seem to be accepting the power imbalance as an automatic and even welcomed state. These individuals often seek active involvement and are ready to provide feedback in the context of the alliance.*

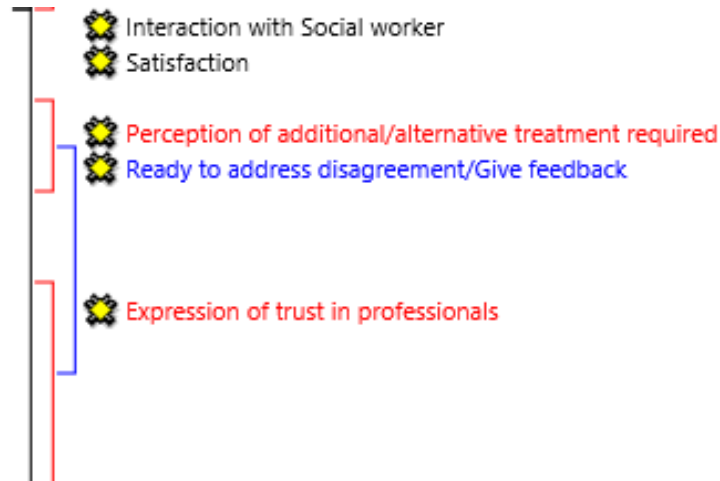
The primary codes which gave rise to this alliance-type were:

*Perceived power imbalance in alliance*  
*Acceptance*  
*Satisfaction with power-balance type in alliance*  
*Active involvement in care*  
*Reference to Traditional Medical Hierarchy*  
*Determination*  
*Expression of trust in professionals*  
*Perceived subjection to expected submission*  
*Ready to address disagreement/ give feedback*

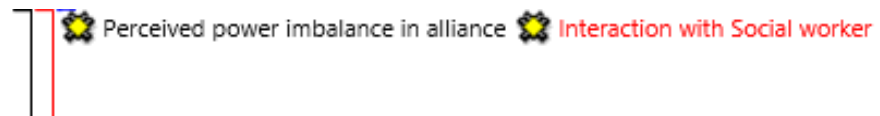


Figure 14: Excerpts from the interview with Care Receiver 5

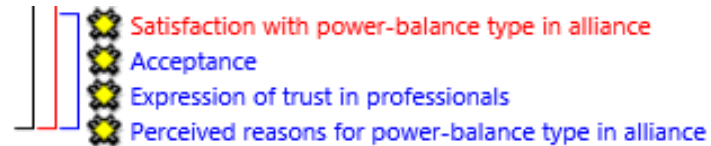
28 I feel quite ok when I am with the social worker. I feel safe. And with her help, I have organised my wardrobe. I wish that the occupational therapist would accompany me home again. I would let the social worker know sometimes if I do not agree with what she says or if I have any feedback. Sometimes I tell her, sometimes I don't. She tells me things for my own benefit. I cannot do without my social worker, she is like a daughter to me. She has other people though, not just me.



38 When I am with the social worker, she is at a higher level than I am.



41 They studied to be like that. And I believe that they should be on top and I just trust in them.



Similarly, in the next page, Figure 15 shows excerpts that describe Care Receiver 4's alliance with the psychiatrist, as coded during the primary analysis process using *Atlas .ti*.

In the secondary analysis process, this was one of the alliances that gave rise to the *Resentment-Opposition* alliance type. As discussed in Chapter 4, this alliance type/discursive theme:

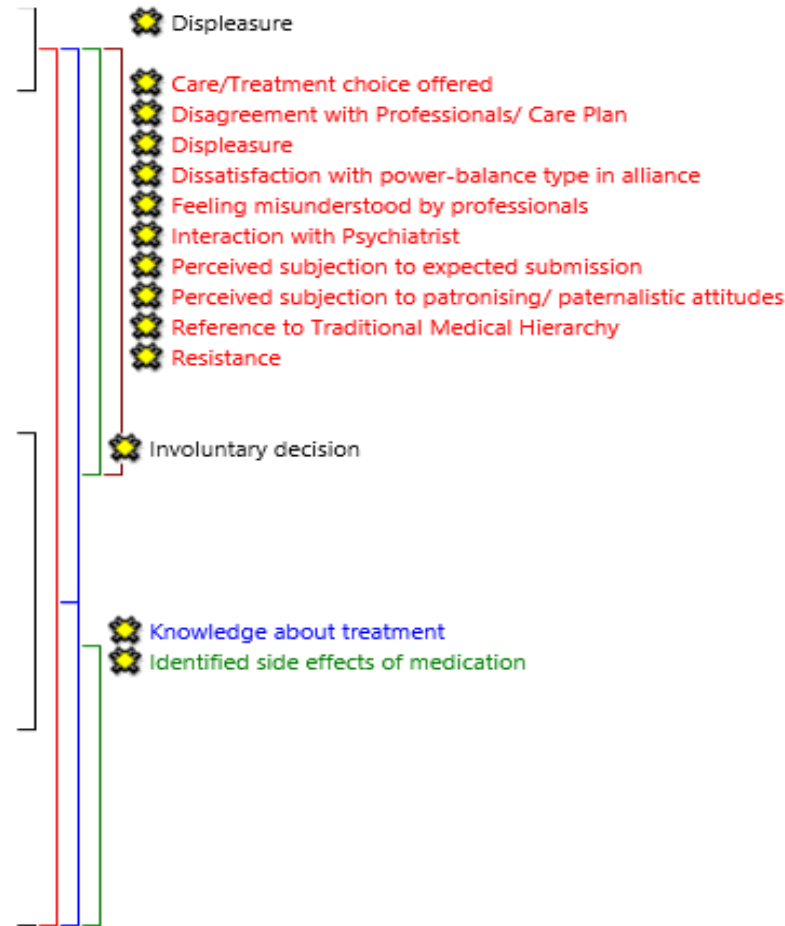
*depicts a group of individuals who seemed to be displeased due to the perceived power imbalance in their alliances with some of the professionals. Most of these individuals showed clear disagreement with the professional involved in the alliance and felt as if their rights were not being respected. Resistance and anger were commonly identified as a result of this alliance-type.*

The primary codes which gave rise to this alliance-type were:

*Perceived power imbalance in alliance*  
*Resistance*  
*Dissatisfaction with power-balance type in alliance*  
*Anger*  
*Displeasure*  
*Discomfort*  
*Perceived subjection to patronising/paternalistic attitudes*  
*Exclusion*  
*Disagreement with professionals and/or care plan*  
*Perceived subjection to expected submission*  
*Perceived subjection to discrediting attitude*

Figure 15: Excerpts from the interview with Care Receiver 4

14 I am not satisfied with the treatment that I am receiving here. I try to speak to the doctor about it but he ignores me. He does not wish to speak to me. Nothing. He does not pay attention. The junior doctors visit but they say that they cannot give me any permissions because they speak to the consultant psychiatrist and he does not wish to give me permissions. He does not even come to see me once weekly. I speak to his doctors. They tell me that they speak to him about me. Now I do not know if they really do. But each time, he does not give me any permissions. I had had permission to go to the main garden accompanied. But I refused to take the injection and he stopped my permission. He wanted to give it to me against my will. I refused it 15 years ago and he still gave it to me. It harms me. I asked him to give me another type of medication - Risperdal. I do not want the other medication (*the original one being given*). When I was young I used to have seizures and that medication is known to cause seizures.



## **Appendix 4: Primary and secondary analysis of medical and nursing records**

### **(i). Primary codes**

The primary thematic coding process of the medical and nursing records led to the identification of fourteen codes, each of which described the data related to it in a particular way. In this manner, some of the codes were directly related to specific knowledge/power themes in the data (e.g. Code: Authoritative terminology). In contrast, other codes that emerged described the data in a non-specific manner (e.g. Code: Treatment/Care description). The following list presents the primary codes and their definition:

#### **Automatic wording**

This refers to terms that have found their way into the psychiatric system and tend to feature routinely and at times, aggressively in written records. These are often found as standalone statements in the records included in the study e.g. *Comfortable night*.

#### **Authoritative terminology**

These are commanding terms that are characterised by a tone that suggests a high expectation of compliance and conformity from the care receiver.

#### **Custodial approach**

This refers to a way of writing that depicts the care receiver as a vulnerable individual who must be protected and ‘mothered’ with little focus, if any, on promoting autonomy and independence. This writing manner often features statements that describe how things are being done *for* the care receiver rather than *with* him/her.

#### **Description of care receiver’s state/progress/actions**

Statements that describe the care receiver’s state, progress or actions carried out.

#### **Feedback from care receiver**

Statements that reflect feedback that has been obtained from the care receiver.

### **Feedback from care receiver's significant others**

Statements that reflect feedback that has been obtained from the care receiver's significant others.

### **Medical terminology**

This consists of wording that is characterised by medical jargon that attempts to describe the care receiver's state/progress/actions or the treatment/care provided.

### **Care receiver involvement**

Statements that indicate that an effort is being made to involve the care receiver in his/her care plan.

### **Care receiver-oriented approach**

A way of writing that indicates that the care provider is focussing on the care receiver's needs and wishes and treating him/her as a unique individual with unique needs.

### **Reference to feedback from other professionals**

Statements that reflect feedback that has been obtained from other professionals.

### **Task orientation**

A way of writing that indicates that the care provider is focussing on completion of routine tasks with little regard for the care receiver's unique needs and wishes.

### **Treatment/Care description**

Statements that describe the treatment/care that is being provided.

### **Use of the care receiver's actual name**

Statements that mention the care receiver's actual name rather than referring to him/her as 'patient' or in the third person.

### **Use of the care receiver's actual words**

Statements that include the care receiver's actual words rather than a care provider's reconstruction of the words said.

## **(ii). Worked examples of primary and secondary analysis**

In the following page, Figure 16 shows an excerpt from Medical Record 9 that has been coded during the primary analysis process using *Atlas.ti*.

When all the transcripts had been coded, secondary analysis was undertaken during which data was compared and patterns could be identified. This led to the identification of the three discursive themes that were described in Chapter 4:

*The Pathological Lens*  
*Depersonalisation*  
*Humanism*

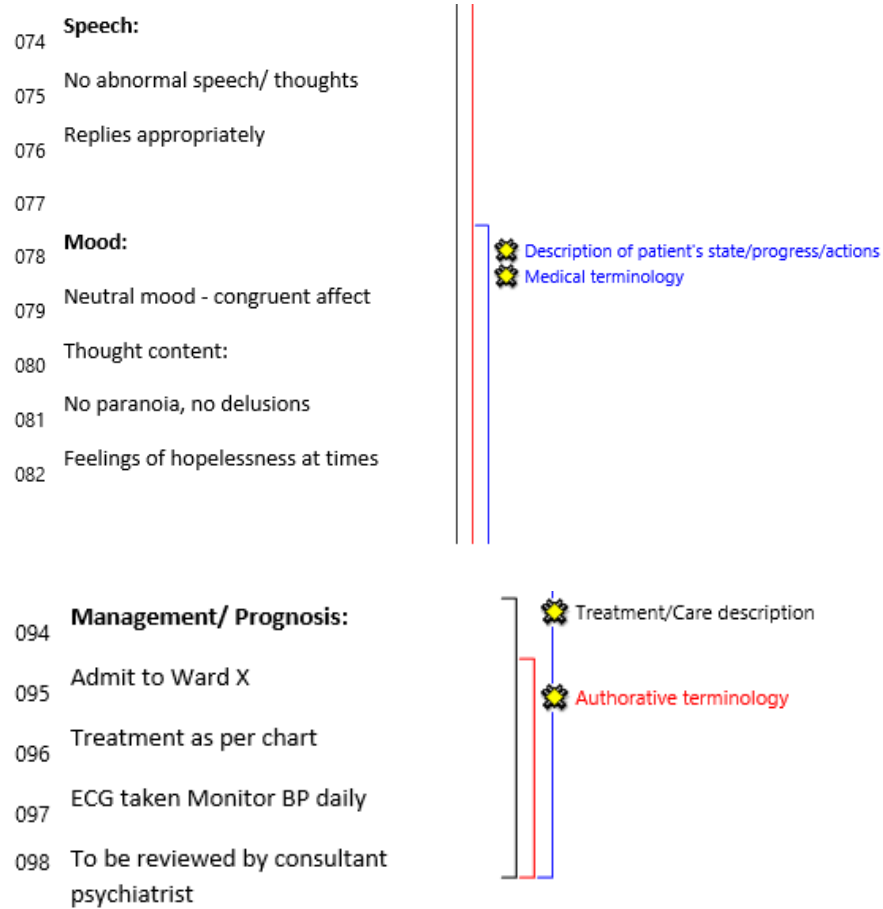
For instance, the excerpt in Figure 16 was one of those which gave rise to the discursive theme named *The Pathological Lens*. As discussed in Chapter 4, this alliance type can be briefly described as:

*discourse that is mainly dominated by the use of technical or pathological terms.*

The primary codes which gave rise to this alliance-type were:

*Medical terminology*  
*Automatic wording*  
*Custodial approach*  
*Authoritative terminology*

Figure 16: Excerpt from Medical Record 9



Similarly, in the next page, Figure 17 shows an excerpt from Nursing Record 1, as coded during the primary analysis process using *Atlas .ti*.

In the secondary analysis process, this was one of the excerpts that gave rise to the discursive theme of *Depersonalisation*. As discussed in Chapter 4, this discursive theme:

*features a way of referring to the therapeutic alliance in terms that tend to mechanicalise the interactions and the entities within it. As a direct consequence, it is felt that the person factor is being removed from the equation by excluding the specific qualities, experiences and other characteristics that contribute to the uniqueness of each individual.*

The primary codes which gave rise to this alliance-type were:

*Task orientation*  
*Automatic wording*  
*Medical terminology*



Figure 17: Excerpt from Nursing Record 1

