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Title:

Professional dissonance and 'schizophrenia': An autoethnography of psychiatric nursing practice in a community mental health team

A thesis presented to the University of Dublin, Trinity College, for the Degree of Doctor of Philosophy in Nursing

By

Mark Monahan

January 2013
Abstract

Background: Toulmin (2002) argues that modern science has embarked upon quests that place an emphasis on the abstract and the theoretical, to the exclusion of the lived realities of people. For much of the 20th century, psychiatry has sought to unlock the secrets of ‘schizophrenia’. This quest, which though firmly aligned with the objectives of science, has neglected the experiences of the people given the diagnosis. In the midst of this neglect, confusion has emerged surrounding the role nurses should play in ‘schizophrenia’. In the emphasis on biomedical perspectives, nurses frequently focus on the diagnosis and processing of care, over human problems and personal development, neglecting the person and their perspectives.

Objective: The objective of this study was to explore the role of psychiatric nurses and how they work with people given a diagnosis of ‘schizophrenia’ in a contemporary mental health practice setting.

Methodology: To explore this area I undertook an autoethnographic study. The methodology was informed by the sensitising concepts of symbolic interactionism (Blumer, 1969) and street-level bureaucracy (Lipsky 2010). As the researcher, I acted as the data collection instrument, joining a community mental health team in an urban/rural setting alongside the team’s clinical nurse specialists (CNS), who provided long-term support to people given the diagnosis. The fieldwork extended over a 12-month period involving both full observer and full participant roles, during which I actively provided nursing care as a full member of the team. I analysed the data, in the form of field notes, interviews and documentary evidence using a ‘grounded theorising’ approach (Hammersley and Atkinson 2007a).

Results: In the analysis, I show how the outcomes for people given a medical diagnosis of schizophrenia are almost entirely fashioned in the relationships they develop with mental health professionals. The origins of these relationships are arbitrary in nature, usually done by random assignment within the community mental health team. In my relationships, I controlled the knowledge I gave to people about ‘schizophrenia’ and its treatment. When working with people, I show how I constructed individualised interpretations of their ‘schizophrenia’ diagnosis based on my values and beliefs. During this time, I found some of these interpretations were ‘at odds’ with other team members.

The core construct to emerge in this study was ‘professional dissonance’, as I attempted to cope with conflicting perspectives on treatment and care. Professional dissonance is a form of ‘cognitive dissonance’ (Festinger, 1957). I found working in the community mental health team challenging, as in the course of my work, I was involved in actions that conflicted with my beliefs about the diagnosis of schizophrenia. I identified four areas where dissonance emerged strongly: the language of schizophrenia, the necessity to provide care within cost constraints, dissonance in attempting to engage people with services and vicarious dissonance where clashes in values and beliefs emerged from the actions of other team members. In response to dissonance, I reveal how I attempted to maintain harmony, and my status within the team, whilst trying to reduce the dissonance I experienced. I did this by using a combination of autonomy, power, and discretion in face-to-face interaction with people, at times ‘covertly’. On reflection, I also explain how in some instances, I placed my own needs and my perception of the ‘best solution’, ahead of the person diagnosed and those of team.
Conclusions: The emergence of individualised interpretations of 'schizophrenia' creates problems and conflict in practice, increasing confusion and leading to variable outcomes for people engaged with services. When working with the diagnosis of schizophrenia, community mental health teams need a capacity to create discursive spaces in time that can accommodate the values, beliefs and perspectives of all members of the multidisciplinary team and service users, encompassed within the values of tolerance, forbearance and patience. A failure to provide these spaces will lead to growing professional dissonance and conflict within teams. I identify that educators need to be aware of how the content they teach radicalises students and clinicians and increases the capacity for dissonance to develop. Educators also need to be aware of developing coping skills with students to enable them to cope with the dissonance they encounter.
Declaration

This thesis has not been submitted as an exercise for a degree at this or any other University. It is entirely my own work, except where it is duly acknowledged in the text.

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Dedication

This study is dedicated to the people who gave me permission to write about their lives and work around the diagnosis of 'schizophrenia'. I am eternally indebted to them for having allowed me share a short period in their lives.

The study is especially dedicated to my family; to my wife Rita who has endured and tolerated this journey every step of the way with me. To my children, Peter, Georgina, Jonathan and Christine who have also stood by me in my struggle. And to my parents and family without whose support I would never have come this far.
Acknowledgements and Thanks

To Agnes Higgins and Jo Murphy-Lawless who supervised this work. Thank you for your guidance and support. It is your knowledge, strength and kind-heartedness that have brought this study to its completion.

Thank you also the School of Nursing and Midwifery, Trinity College, for their funding and support in undertaking the study. Also to my colleagues in the school, who always provided support, a kind ear and great forbearance, as the study came to occupy almost every conversation we had.
Summary

Since its inception in 1911, ‘Schizophrenia’ has become psychiatry’s ‘raison d’etre’ (Bracken and Thomas, 1999). ‘Schizophrenia’ and its biological underpinnings became a contested and contentious area from an early stage. Working with the diagnosis of ‘schizophrenia’ represents a significant part of the work of psychiatric nurses and as psychiatric nursing enters a new century, confusion surrounds exactly how psychiatric nurses should work with people given the diagnosis.

This thesis is an exploration of how psychiatric nurses work with people given a medical diagnosis of schizophrenia in contemporary psychiatric nursing practice. It is an autoethnography. To gather the information for this ethnography I left my post as a lecturer in nursing and returned to clinical practice for a period of one year. I worked in a community mental health team alongside three clinical nurse specialists (CNS) and other members of a multidisciplinary community mental health team. The primary responsibility of the clinical nurse specialists was to provide care and long-term support to people given a diagnosis of schizophrenia. I accepted responsibility for the care of 15 people in this group, eight of whom had a diagnosis in the ICD-10 ‘Schizophrenia, Schizotypal and Delusional Disorder’ categories F20-29.

The thesis is organised around nine chapters, of which a summary follows:

Chapter 1: Introduction to thesis

This chapter details my career as a psychiatric nurse and the developments that took place in mental health services in Ireland during that time. It also explains why I came to study the area.

Chapter 2: Foreshadowed Problems

Rather than a formal literature review to provide direction to a study, Malinowski (1922) favoured the premise of ‘foreshadowed problems’, directions in which we could look in ethnography rather than preconceived notions. This section of the thesis explores the relationships of science and psychiatry in pursuing a solution to the problems of ‘schizophrenia’. It examines biological and environmental theories of causation and the attempts to unify both of these perspectives. It also looks at psychiatric nursing’s response to the diagnosis and visits one of the darkest periods of psychiatry, The Holocaust, to examine how people given the diagnosis were treated then.

Chapter 3: Methodology

The methodology chapter provides detail on how the study was undertaken. It outlines the methodological assumptions in the form of two sensitising concepts; symbolic interactionism and Lipsky’s (2010) theory of ‘street-level bureaucracy’. The chapter explains the processes used for data collection and analysis, and has discussions on ethics and quality in ethnography.

Chapter 4: An Ethnographic Description of the Field

Chapter 4 provides a description of the field. I chose Glenvilly, as a ‘symbolic location’, (Keith, 1993), representative of the ‘Vision for Change’ (2006) for Irish mental health services. It chronicles the activity of a Community Mental Health Team (CMHT), its team members and resources. It also introduces the central characters of the ethnography and their day-to-day relationships.
Chapter 5: Cognitive Dissonance: A Primer

The central construct to emerge from this ethnography is ‘professional dissonance’ (Taylor, 2007). This is a particular form of ‘cognitive dissonance’ (Festinger, 1957). This chapter provides a background on what ‘cognitive dissonance’ is and how people try to reduce dissonance when they experience it.

I present the findings and analysis of the data over three chapters (6, 7 and 8). They explore how the diagnosis of ‘schizophrenia’ caused dissonance for me and the people who work with it. They also show the actions I took in reducing the dissonance I experienced. The discussion on the findings is interwoven with contemporary literature with the analysis.

Chapter 6: The dissonance caused by language and holding different beliefs

As professionals, we are comfortable in using medicalised language, but we rarely think about the connotations that the term ‘schizophrenia’ holds. I found the language of schizophrenia caused dissonance. This chapter explores how the term effected the relationships we have with people given the diagnosis, their families and with colleagues. It looks at how I attempted to cope with the dissonance the term causes by formulating my own ‘individualised’ interpretations of schizophrenia. The chapter also looks at dissonance arising from needing to work with the diagnosis of ‘schizophrenia’ within the confines of limited service resources.

Chapter 7: Dissonance arising from patterns of engagement

Trying to engage with people with a diagnosis of schizophrenia with mental health services can prove difficult. This chapter explores how I, as a part of a service, attempted to get the forms of engagement that would allow the service to provide the best care it could. I use Foucault concepts of creating docile bodies, surveillance and control in doing this. At the end of the chapter, I explore boundary breaking and the use of coercion.

Chapter 8: Dissonance reduction, the effects of power and the use of discretion

The third chapter of analysis focuses upon how I attempted to cope with the dissonance ‘schizophrenia’ causes. I explore the interlinking concepts of autonomy, discretion and power and how these effect interpersonal relationships and the outcomes for care for people given the diagnosis.

Chapter 9: Discussion

In the final chapter, I present a discussion on the main findings and the conclusions I drew from the data. I discuss the problems that using individualised interpretations bring, the impact of educators and the content they teach, the lessons learned from the methodology and the implications for further research. I explore the problems of multi-disciplinary team working in areas where there is ambiguity and varying opinion as to the most appropriate approaches to care. The conclusion identifies a need for broad-based approaches to care within teams with discursive spaces that can accommodate varying beliefs about the diagnosis of schizophrenia; spaces where discussions can occur that have ‘modesty about one’s capacity and self-awareness of self-presentation’.
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Chapter 1: Introduction to thesis

“The concept of schizophrenia is surrounded by chaos and controversy”

(Boyle 2002: x)

This thesis began as an exploration of how psychiatric nurses work with people with a medical diagnosis of schizophrenia. In the five years since I started this work, it has seen me travel a path where I now question how psychiatric nurses cope when their beliefs and values about the diagnosis of schizophrenia conflict with those of other staff, when working as part of a multidisciplinary team. The thesis explores cognitive dissonance, in the guise of 'professional dissonance' and discusses how in an attempt to alleviate this dissonance, nurses act in particular ways. In this opening section, I would like to explain what brought me to question the role of the psychiatric nurse working with people with a medical diagnosis of schizophrenia.

This question needs to be considered in the context of who I am and the experiences that led me to formulate this question. As an eighteen year old, I entered psychiatric nursing in 1980 and following three years' training, received a certificate allowing me to have my name entered on the An Bord Altranais (The Irish Nursing Board) psychiatric nursing division of the register in Ireland. I spent most of the next 20 years working in an asylum-style mental hospital, established in 1816. This hospital had 1200 'inmates' spread over a 74-acre campus in 1980. Today fewer than 50 beds remain. The 1980s represented a period of unprecedented change in Irish mental healthcare and the subsequent years saw the landscape radically altered. 'Integration', the dismantling of staff and patient gender segregation, had just dawned in the 'asylum'. Previously under the terms of the Mental Treatment Act (Government of Ireland, 1945) a male attendant could not be employed in the care of a female patient, the 'asylum' where I worked having been divided between an upper house (with male patients and male staff) and a lower house (with female patients and female staff). A landmark case occurred in 1983 when one male student became the first male nurse to work in a female unit in the hospital.

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1 There is debate surrounding the terminology nurses should use to describe themselves when working in the area of mental health. For the purpose of this study, I will use the term psychiatric nurse rather than mental health nurse as it is the term currently used for registration purposes in the Republic of Ireland.


3 During this time provision of health care in Ireland was divided geographically into eight Regional Health Board Areas. Each of these areas was subdivided along county boundaries with a large centralised district mental hospital.

Upon qualification in 1983, my first experience as a staff nurse was a year-long placement in a community-based acute admission unit. The unit, although not newly built, was a relatively recent development when opened three years earlier. It marked a historic change in the way mental health care was delivered in the country. Prior to that time, people with mental health problems received care at the admission units, situated on the campuses of the large district mental hospitals. This was a small local unit with thirty beds, serving its own catchment area of 30,000 people. The unit offered a glimpse of the ‘Future’, after which I returned to find an institution mobilising for change. My return coincided with the publication of ‘Planning for the Future’ (Department of Health 1984), a blueprint for mental health care in the community in Ireland. The policy proposed the dismantling of ‘asylum’-based care, with care to be provided in acute local community units on the campuses of general hospitals. It also proposed community-based psychiatry delivered by multi-disciplinary teams, with day hospitals, day centres and local out-patient clinics. Psychiatric nurses were to work outside of the ‘asylum walls’ and become ‘community psychiatric nurses’.

The implementation of ‘Planning for the Future’ (Department of Health 1984) proved difficult for those working in the mental health services, marked by union unrest and regular confrontation with services management. The period saw a dramatic reduction in bed numbers, the hospital population on campus fell from the 1200 of 1980 to approximately 350 in 1987. Those not considered to be true ‘psychiatric cases’ were relocated to more appropriate services; the then ‘mental handicap’ services and ‘geriatrics’ services receiving the bulk of the inpatient transfers. Backed by European Union grant funding, rehabilitation psychiatry became the order of the day with a drive towards the deinstitutionalisation of long-term residents. A psychosocial education program for ‘long-stay patients’ then housed in the buildings of the old ‘Lower House’ and ‘Block 1’ commenced, staffed by a group of nurses and occupational therapists, to prepare long-term hospital residents with skills to allow them to return to the community. The program emptied people from ‘back wards’ in a phase characterised by the rise of community-based psychiatric ‘hostels’ principally located around the outskirts of the institution.

The decision to implement ‘Planning for the Future’ (Department of Health 1984) coincided with a major downturn in the Irish economy, a time of serious cutbacks in financing for healthcare in general and mental health in particular. The need for funding of places in the community led to rapid bed closure in the ‘asylum’ and for those individuals whose care necessitated treatment in the asylum, most of whom were diagnosed with ‘schizophrenia’, over-crowding was the order of the day. Units with thirty beds, by day accommodated up to fifty. At seven o’clock in the evening my job was to move the overflow to temporary accommodation for the night, in a practice dubbed ‘lodging out’. The ‘mobile’ population ‘paraded’ around the grounds in search

1977. These regulations required the Regional Health Boards to ensure integration of psychiatric nursing staff in mental health units.

In Dublin, the regional health board was subdivided into smaller ‘hospital catchment’ areas, that were subsequently divided into ‘local catchment’ areas allocated to individual consultant psychiatrists.

The hospital received funding from the European Union to develop the ‘Demonstration Re-socialisation Pilot Project of Europe’. This programme focused upon developing a rehabilitation services to assist people considered ‘long-stay’ and ‘institutionalised’.
of a bed; subsequently ‘readmitted’ to their ‘parent unit’ the following morning. These practices within the institution drove me to work in a private psychiatric hospital.

After six years’ experience as a staff nurse, I entered general nurse training. I qualified with a certificate in registered general nursing in 1990 and from economic necessity returned to the public psychiatric service. The public sector, still suffering from the effects of recession and struggling to implement a community model of psychiatry during a time of cutbacks, proved to be an area of industrial unrest, with a workforce seriously under-manned and under-resourced. I too became engaged in union activity ultimately becoming branch secretary in the service.

Daly & Walsh (2012) identify that in 2011, schizophrenia [ICD-10, F20-29] accounts for 20% of all, 12% of first and 24.1% of readmissions to Irish psychiatric facilities, ‘schizophrenia’ also represents the highest rate for involuntary admission (17.4%) and 33% of people admitted with no fixed abode. After admissions for organic mental disorder, people with a diagnosis of ‘schizophrenia’ had the highest duration of stay in Irish mental health units at 36 days, representing 39% of in-patient day occupancy. Over the course of my career, schizophrenia was the diagnosis that I encountered most frequently. As a student nurse, I learned how to apply the biomedical classifications of psychiatry, especially those of Bleuer (1911) and Schneider (1959). I accepted the content of the classes on ‘schizophrenia’ without question, unaware of the emerging critiques of psychiatry. Yet, what amazed me was how different people diagnosed with schizophrenia were in reality from the image painted in my textbooks. People did not have the propensity of hallucinatory experience that the textbooks led me to believe. Neither did I meet the assortment of schizophrenia types presented in the books. ‘Catatonic schizophrenics’ could not be found standing in waxy-like positions on the corridors of the asylum, and in a day ‘Simple Schizophrenics’ became reclassified as ‘Paranoid Schizophrenics’ with a change of psychiatrist. My formal educative process taught me to look for the ‘first rank symptoms of schizophrenia’ (Schneider 1959) yet in many instances of the diagnosis, these criteria were not present. This puzzled me. The people I found given the diagnosis were those at odds with the world, those who had difficulty fitting in, those who had difficulty living with their family, those having difficulty living with their experiences. The validity and reliability of both Bleuer’s (1911) and Schneider’s (1959) classifications as indicators of the diagnosis are now questioned (Bertelsen 2002). It appeared as though the diagnosis was a movable feast as regards its criteria. It was easy to recognize conditions like diabetes and congestive cardiac failure, yet not so in the

7 In the ‘Unhealthy State’, Wren (2003:72-77) documents the political, economic and cultural forces that have shaped a ‘shocking indictment of health denied’ by the Irish health service. She notes the first raft of cutbacks occurring under the Fine Gael/Labour coalition of the early 1980s. In the election of 1987, Fianna Fáil campaigned on a platform of no cuts in health expenditure, however confronted by looming economic crisis the government implemented the most more severe cuts than the previous administration with ‘catastrophic and long lasting effect (p.74).

8 In 1959, Schneider introduced the concept of ‘first rank symptoms’. Schneider’s (1959) classification received wider acceptance when Wing et al (1974) in incorporated the classification into the Present State Exam, considered to be the first major structured interview of patients. The classification identifies four categories of phenomenological experience: (i) delusion, characterised by delusional perception (ii) auditory hallucinations, characterised by audible thoughts, voices heard arguing or voices heard commenting on one’s actions, (iii) passivity experiences in the forms of passivity of impulse, volition, affect or somatic passivity and (iv) formalised thought disorder manifest in thought withdrawal, thought insertion and thought broadcasting.
diagnosis of schizophrenia. Ambiguities existed within the competing medical diagnostic classifications of ICD-10\(^9\) and DSM-IV\(^{10}\) and potentially an individual could be diagnosed with schizophrenia in one classification, yet might not meet the criteria in the other (Cheniaux et al. 2009). In practice, my colleagues discouraged me from engaging with the symptoms of the illness. As in Wolpe (1958) and Fish’s ‘Schizophrenia’ (Hamilton 1980), we did not discuss hallucinations or delusions because the authoritative voice of psychiatry said they could not be understood rationally. To explore hallucinations or delusions would only reinforce the beliefs and exacerbate the person's psychosis, effectively ‘taking the lid off a can of worms’.

The dismantling of the ‘asylum’, as outlined above, resulted in a refocusing of the hospital's use, and its role became dedicated to the management and care of individuals who presented with violence and aggression as a component of their 'illness'. Following my return in 1990, I spent the next 10 years of my life working in this ‘secure unit’ incarnation of the ‘asylum’. These were still segregated environments, both in relation to gender and in a staff/patient divide. The predominant model of care was ‘surveillance and control’. Life was governed by routine, the individual was dictated to as regards when he rose, when he ate, when he slept, and whether he bathed. Within the ‘panopticon’, observation was the order of the day, with rooms monitored by CCTV and entry and exit governed on an ‘air-lock’ principle. Medication was prescribed by psychiatrists and administered by nurses. Non-conformity was not countenanced. ‘Control and Restraint’ became one of the most essential in-service education components. On reflection, the ‘regime’ did not view people outside of this context. Other versions or theories of schizophrenia, such as trauma and abuse and the behaviour that led one to be diagnosed with the condition were rarely explored. What was remarkable was the frequency with which people returned to this environment, victims of the 'revolving door' and the stigmatization that the label of a 'history of violence and aggression' brings - a label easy to acquire and difficult to remove. Despite the notion that individuals are complex and that in many situations circumstances other than symptoms contributed to the person's admission, intervention outside of pharmacological was rarely considered. Frequently, I would sit on the floor of a

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\(^9\) The ICD-10 is the International Statistical Classification of Diseases and Related Health Problems, a medical classification of illness released in 1992. It represents the 10th version of the classification, originally established in 1900 with the first international conference on classifying causes of death. Now under the auspices of the United Nations, the World Health Organization (WHO) took control of the classification in 1948, releasing the most substantial revision of the classification, ICD-6, in 1949. Although primarily oriented to general illness, it contains a specific chapter (Chapter V) classifying mental and behavioural disorder.

\(^{10}\) The DSM-IV or Diagnostic and Statistical Manual of Mental Disorders Version 4 is also a classification of mental and behavioural disorder used officially in the United States as a common language for clinicians, researchers, regulators and insurance bodies. Originally published in 1952, the fourth revision was produced in in 1994, with a text revision released in 2000 (DSM-IV TR). The Diagnostic and Statistical Manual of Mental Disorders Version (DSM) V was published following the acceptance of this thesis on 18th May 2013 subject to minor amendment. Introducing a new overarching category of ‘Schizophrenia spectrum and other psychotic disorders’ the revised classification has retained the central ‘Schizophrenia’ diagnosis, however, it has removed the previous subtype classifications of paranoid, hebephrenic, simple, catatonic and residual. In the process it has also broadened the categorisations of delusional disorders and other psychotic subtypes. Catatonia is now categorised as an adjunct phenomenon either related to other disorders or of unspecified nature. Braff et al (2013:753) justify the removal of subtypes in the DSM-5 schizophrenia classification as justified “by the lack of stability, validity, heterogeneity reduction, and practical utility in the scientific literature”.

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seclusion room with a person, the sentiment 'surely there is more that I can be doing here' echoing through my mind. I felt I had little time and few resources to pursue the answer to the question. These memories stayed with me. I could only describe my education as 'theory heavy and practice light'; that theory founded on biological interpretations and pharmacological intervention. I knew every 'pill' on the trolley and thought I could explain the biological theories well. However, although I knew the technical elements, I felt my education prepared me poorly for working and engaging with the person diagnosed with 'schizophrenia'.

I entered nursing with the objective that after a period learning how to nurse, I wanted to become an educator. I thought that ten years' experience would be a good round figure; my opportunity finally came after 20 years. I joined the staff of a school of psychiatric nursing in 2000 and moved into a university in 2004. In the context of my experiences sitting on a seclusion room floor, I hoped that I might be able to help students acquire ways that they could 'do more'. This desire fuelled my decision to explore the work that psychiatric nurses do with people with a diagnosis of schizophrenia, and in the university the primary focus of my work became teaching about the nursing care of people with enduring mental health problems.

In my ignorance and lack of ability in trying to communicate and work with people diagnosed with schizophrenia, my failings and my struggles with my past actions, I embarked upon this journey in the hope to develop a better understanding of the condition 'labelled' schizophrenia. I also hoped I might answer the question I asked many years before, 'was there more I could do?' In my attempt to do this, given that I had left clinical practice for almost ten years, I decided that I would return to clinical practice to see what had happened in the intervening years. I felt that conducting an ethnography would allow me to re-experience the role of the psychiatric nurse working with people given a diagnosis of schizophrenia. I would attempt to find a clinical environment at the cutting edge of Irish clinical practice, built around the proposed model for care in Ireland, 'A Vision for Change' (2006). I wanted to gain as authentic an experience as I possibly could. To do this I decided that I would use a variant of ethnography, autoethnography, whereby I would myself undertake the care of people given a diagnosis of schizophrenia first hand. This I felt would allow me to examine the 'true' feelings, beliefs and values of a nurse (myself) as I attempted to deal with the challenges of day to day practice. Accordingly, this thesis follows an unconventional format. It is written in the first person and does not contain a substantive review of literature. The work is influenced by Foucault's notion of 'eventalisation' (Burchell et al. 1991), a standpoint where the 'situatedness' of problems, the relationship of the problem in time and context, provides for the presentation, analysis and discussion of the problem at the point of its arising. In a departure from convention, there are three findings chapters replete with analysis and discussions. Throughout this thesis when referring to the diagnosis of 'schizophrenia', I have placed this term in inverted commas. This is done to reflect the contested nature of the diagnosis of 'schizophrenia' and the rejection of the diagnostic term by many people as both stigmatising and labelling.

In this exploration of values and beliefs about the diagnosis of 'schizophrenia', I have experienced considerable confusion; some of this confusion is reflected in the next chapter (Chapter 2), in what I shall term 'foreshadowed problems'. It starts with an exploration of science, madness and psychiatry; examining current approaches to mental ill health and thinking on the diagnosis of 'schizophrenia'. It proceeds to consider psychiatric nursing's
perspectives on working with people with the diagnosis of schizophrenia and concludes with
reflection of one of the darkest periods of psychiatry and psychiatric nursing in the care of
people given the diagnosis of schizophrenia, ‘Holocaust psychiatry’ in Germany between 1934
and 1945.

In Chapter 3, I describe the method used to construct this ethnography, including a discussion
on the specific ethnographic approach used, autoethnography. The chapter details the
rationale for selecting the approach, the location, the participants and the data collection
methods. It also provides a discussion on the ethical principles followed and the attempts to
ensure quality in the work. The chapter contains the details of how I conducted the analysis
using Hammersley and Atkinson’s (2007) ‘grounded theorising’. Chapter 4 provides a
description of the fieldwork setting and my immersion in the working life of psychiatric nurses
and other staff in a community mental health team. It presents the day-to-day realities of work
in the team, such as coping with multiple caseloads and potentially conflicting responsibilities.
Throughout this chapter and in subsequent chapters and discussions I have used pseudonyms
for all of the places and people mentioned. In Chapter 5, I present the core construct of the
ethnography, professional dissonance, which emerged from the findings of the fieldwork.

Presented in chapters 6, 7 and 8 are the details of the analysis of the events drawn from the
fieldwork, with discussion on the aspects as they emerged on life of working with people with
a diagnosis of schizophrenia. Chapter 9 contains a discussion on the findings as a whole and
finishes with the conclusions on the central construct of the ethnography, the ‘professional
dissonance’ that emerges when working with people given the diagnosis of schizophrenia.
Chapter 2: Foreshadowed Problems

'Research always begins with some problem or set of issues, at the very least it starts from what Malinowski (1922) referred to as 'foreshadowed problems'”

(Hammersley & Atkinson 2007:21)

Malinowski (1922:9) described preconceived ideas as ‘pernicious in any scientific work’ and favoured the premise of ‘foreshadowed problems’. He believed that rather than a determination to prove or disprove preconceived notions on a subject, the more ‘foreshadowed problems’ a researcher could bring to the field, the greater the likelihood he or she had of seeing ‘facts’, and how these might relate to emerging theory. In this section, I will present the ‘foreshadowed problems’ arising from various perspectives on the diagnosis of ‘schizophrenia’ and how these raise critical challenges for psychiatric nurses. These include foreshadowed problems in science, psychiatry, and psychiatric nursing. I begin with sociological considerations of madness and psychiatry.

The emergence of psychiatry in the control of the ‘mad’ man

In ‘Madness and Civilization’ Foucault (2001) documented the changing perspectives on madness within Western society and the struggle for control over the body of the ‘mad’ man. According to Foucault (2001), in the unfolding discourse, two groups came to dominate the discussion, psychiatry, an emerging arm of medicine, and those championing ‘moral management’

Over time, the pendulum of the dominant discourse in society swings, each in turn holding sway and coming to affect how psychiatry reconsiders its role as regulator (Foucault, 1997:42-43).

Reil (1808), introduced the term ‘psychiatry’ into medicine in 1808. His formulation excluded philosophers and psychologists, proposing psychiatry as a solely medical speciality, in which only the very best physicians should engage (Marneros 2008). He emphasised the universality of ‘mental disease’, proposing the mental institution as the centre for care. He also considered ‘medical psychology’ fundamental to psychiatric training. Since this time, the discourse of medicine and that of psychiatry’s ‘illness perspective’ has continued to gain favour, perhaps up to the moment of the anti-psychiatry movement (Foucault, 1997:45). Armed by a ‘privilege of expertise’, psychiatry took up its role of truth production on the basis of its ‘scientific knowledge ... that authorizes [the psychiatrist] to intervene and decide’ (Foucault, 1997:44).

Pilgrim (2007) argues that the term ‘schizophrenia’ is a ‘psychiatric diagnosis’ most often applied to people who experience idiosyncratic phenomena, in particular hearing voices, labelled ‘auditory hallucination’ in the medical lexicon, or holding fixed strange beliefs labelled as ‘delusion’. Bracken and Thomas (1999) consider that for much of the 20th century psychiatry’s quest to unlock the secrets of ‘schizophrenia’ became its ‘raison d’etre’. In this

11 Boyle (2002) identifies that ‘moral management’, as espoused in the ideas of Pinel, challenged the notion of insanity as an organic disease believing that psychological intervention was required. Tukes, also considered an exponent of ‘moral management’ principles, was more pragmatic. Whilst seeing the benefit of psychological intervention, he did not rule out the possibility of underlying physiological cause and the possibility of ‘the reciprocal action of mind on brain’ (Boyle(2002:29)
pursuit, psychiatry created the stigmatising identity of the 'schizophrenic', an individual over whom psychiatry had power, creating a perception in society that they as 'experts', need to control.

**Foreshadowed problems arising from science's 'Quest for Certainty'**

Science in general, medical science, and perhaps above all psychiatry, all function in particular ways that are important to critique. In the past 200 years, the emergence of the 'biomedical' perspective in westernised culture as the primary 'folk'^12 explanation of illness has increased the reliance upon medicine and science to explain phenomena related to health. During this time, medicine emerged in a hegemonic position to exert huge degrees of control over an individual's life (Foucault 1980). According to Lyotard (1984), modern science has sought to establish universal rules, which he calls 'meta' or 'grand' narratives. Lyotard sees these narratives as forming a basis in society for the rules and regulations on which it makes decisions and how it determines what constitutes truth. Thus, modern science embarks upon 'grand' quests in pursuit of these rules, the quest lying in the centrality of science. However, Lyotard (1984) points out that a 'grand' narrative when implemented creates significant problems for the legitimation of knowledge and when implemented as supposedly complete, as in the case of 'Marxism' in the Soviet Union, they seem to go calamitously astray. Boyle (2002) considers 'schizophrenia' is an example of a grand narrative.

A foreshadowed problem in 'schizophrenia' is the 'quest for certainty' for a universal interpretation through diagnosis. In *Cosmopolis*, Stephen Toulmin (1992:160) argues that the roots of modern science's "Quest for Certainty" have led to the abandonment of solutions to practical issues, in favour of a search for the abstract and theoretical. The priority of 'modernity' is exactitude and rigour; it expects people to complete projects without letting 'emotion' enter the equation. As a method of problem solving, 'modernity' removed problems from their 'situatedness' in an attempt to avoid any distractions that 'nature' or 'humanity' might bring. It placed priority on abstract demands over scepticism, which is based upon a 'myth' that it was possible to make a fresh start. Foucault believed this was not possible, believing that in analysis, context needs to be considered in all its complexity, that the 'local and context' needed to be applied in analysis, an approach he described as 'eventalisation' (Burchell *et al.* 1991). The principal challenge to modernity is its inability to resolve the dichotomous position between the theoretical and the practical.

Toulmin sees the birth of the 'modern' age, as owing its origins to 16th Century Humanism. The 17th Century 'Enlightenment' characterised by Descartes and Newton, he regards as an aberrant strand of 'modern' thinking. In the guise of Descartes' 'coup d'état', science placed an emphasis on 'universal timeless principles', at the expense of diversified thinking, principally focusing on the intellectual aspects of reasoning (Toulmin, 1997:168). Science, following this strand of thinking, he believes has ended up in a cul-de-sac of theoretical arguments and 'absolutism' that lacks 'practicality'. Toulmin (1992.ix) argues that the pillars of modern thought^13 also led to a devaluation of other schools of thought, such of rhetoric and ethics and has resulted in a

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^12 Considered as possibly Germanic in origin, arising from the word 'volk', in common English usage reflects that accepted by the "common people" of society.

^13 Mathematical exactitude, logical rigour, intellectual certainty and moral purity.
casting aside of 'time' and 'context' in the solution of problems, so central to Foucault's 'eventalisation'.

For Toulmin, Descartes' mind/body dichotomy has divided disciplines. Using Toulmin's principles, the second foreshadowed problem is the manner in which the syndrome 'schizophrenia' represents an 'unreconstructed' modernist interpretation of a human condition. Psychiatry accepts that 'schizophrenia' exists, believing it located either within the body or having origins in external factors. Science, in search of the 'absolute', unquestioningly researches schizophrenia in a reductionist manner to uncover 'universal timeless principles' devoid of 'emotional distractions'. As in other sciences, it hopes for a unifying theory to complete a 'grand' schizophrenia narrative. However, for those given the diagnosis of 'schizophrenia', for their families and for me as a practitioner, the diagnosis of 'schizophrenia' is not 'devoid of' but 'fraught' with emotion.

*An exegesis of Foucault's lectures on 'Psychiatric Power'*

Another area of foreshadowed problems follows on from Toulmin and draws upon the work of Michel Foucault. In the lectures given between 1973 and 1974 at the Collège de France, Foucault (2008) revisited his earlier consideration of 'Madness and Civilisation'. These lectures catalogued 'disciplinary power' in psychiatry and identified themes, which he later elaborated upon in his work 'Discipline and Punish' (Foucault 1991), namely those of 'surveillance', the 'ordering of activity' and 'dressage of the body'. In 'Psychiatric Power', the psychiatrist emerges in a role akin to that of prison supervisor.

Foucault identifies a specific problem for psychiatry, which is different to the one present for general medicine\(^\text{1}\). He reasons that by the beginning of the nineteenth century, psychiatry has both assumed and been given the role of authorising a person's madness or otherwise for a broader society. It becomes concerned about the risks attached to madness as unregulated behaviour in its midst, leading to the sense that it must be interned and cordoned off (Foucault, 1997: 41-42). Thus he writes that internment in the hospital made it possible 'to uncover the truth of mental illness' but also to confront 'a disturbed will, a perverted passion' with 'a sound will and orthodox passions' (Foucault, 1997:43). Psychiatry's primary role is to establish for society whether in a particular circumstance, madness is genuine or a simulation. Because of this requirement, he sees psychiatry as 'saddled' with the need to make 'absolute' diagnoses. Its dilemma is unlike that of medicine, with no scope for differential diagnosis.

Accordingly, the presence of madness remains an 'unverifiable' certainty at any given point in time, its presence always needing testing. Consequently, psychiatry must use a 'trial' or 'test' to establish madness. Foucault equates this with the use of 'test' and 'torture' in the 'Inquisition'. The test becomes not one of 'truth' based upon verifiable knowledge but a test of the person's relationship with 'reality'. To enable psychiatry to test for the presence of madness, Foucault (2008:159) saw it necessary for the asylum to become 'imbued with the

\(^\text{1}\) Of course it can be argued that there are branches of medicine, such as epidemiology, with the focus on infection and epidemic disease which also carry the weight of social concerns and views about risk, safety, and quarantine. Foucault comments on how Pasteur's work on infection both sullied doctors of general medicine as carriers of disease with their hands 'gliding' over the patient's body, but also gave them 'a new innocence' and a new source of power and status (Foucault, 1997:41).
psychiatrist's rule" and the psychiatrist to exercise power over the person. The resulting relationship becomes combative; one which Foucault believes always favours the psychiatrist, were the psychiatrist imposes his 'truths' upon the patient who is 'bludgeoned' into submission (Philo, 2007:157). Philo (2007:157) notes that the 'crucial irony' from Foucault's perspective is that the psychiatrist has 'no truths, he is no possessor of true medical knowledge about madness as illness and in fact the only 'real truth' is that he has worked out a few tactics for cajoling mad people into acting not mad'.

Foucault (2008) believed that psychiatry had an acute problem, the absence of an epistemic grid in a largely accepted and well-organised knowledge base. He identifies from its earliest beginnings that challenge existed to hypothesised organic causes underpinning psychiatric knowledge. Philo (2007:158-159) highlights Foucault's position that in the absence of answers, psychiatry resorts to bullying patients "into acting out a version of sanity", thereby revealing the "nakedness of psychiatric power".

Foucault (2008) invited his audience to note power and the nexus of power and knowledge. Drawing from his earlier 'Birth of the Clinic' (1963), Foucault links the significance for psychiatry of the teaching function of the mental hospital with the importance of the 'medical gaze'. He saw the questioning of patients and the teaching of students, in the "grand round" or 'clinic', as fundamental to the creation of psychiatric power/knowledge. He identified the 'clinic' as providing the appearance of knowledge in a scene for both student and patient, legitimising the medical perspective and reinforcing the psychiatrist's belief in the validity of 'his' knowledge. Foucault (2008:189) also identified the infiltration of psychiatry across society, installing psychiatric power within the 'controlling' functions of Western society's institutions; a practice he called 'psy-functions'. He saw the result of embedding 'psy-function' in society as 'madness' becoming cloaked in 'increasing concoctions' of psychiatric knowledge, characterised in the language of symptomatology, journal articles and the 'clinic', the knowledge taken as truthful because the institution of 'psychiatry' speaks.

**Foreshadowed problems arising from psychiatry's 'narratives' of schizophrenia**

"Schizophrenia' remains an enigma"

Harrison (1997:285)

In this section, I wish to explore the foreshadowed problems arising from psychiatry's narratives of 'schizophrenia'. Post-modern perspectives are highly sceptical of 'legitimising narratives', as those with 'authority' hold power in determining what constitutes 'an authority' (Rolfe 2001). Hopton (2006) contends that the result of the 'anti-psychiatry era' was the emergence of a stronger evidence-based medicine, that legitimised psychiatric research and emphasised its 'scientific' nature using Randomised Control Trials (RCT). Bracken & Thomas (1999) contend that psychiatry's search for schizophrenia has:

'... left no aspect of human experience untouched by biochemical research. But there is an ever widening gulf between the unreal world of neuroscience research, and the lives
that are lived under the shadow of the label 'schizophrenia', lives dulled by drugs and blighted by stigma.'

A study of recent theory and practices surrounding the diagnosis of 'schizophrenia' show it as a highly complex and far from straightforward diagnosis, with opinions as to the cause and most effective approaches to care having changed radically over time (Bentall et al. 1988). Theories evolve and at times fall out of favour, only to be subsequently resurrected following the 'latest' discovery. The majority of research centres on causation, dominated by those locating schizophrenia's origins in bodily abnormality or as a response to 'life experiences' that profoundly affect people. Periodically, theories emerge attempting to unite these two perspectives in meta-narrative form. Presented in the following sections are various theories on incidence and the biological underpinning of 'schizophrenia'. These include genetics theories, neurotransmitter involvement, altered brain structures, and other physiological causes believed to contribute to the emergence of the illness diagnosed as 'schizophrenia.'

**Incidence and prevalence data on the diagnosis of 'schizophrenia' from psychiatric research**

Dicker (1992:82) defines incidence as 'a measure of the frequency with which an event, such as a new case of illness, occurs in a population over a period of time'. The common notion of 'schizophrenia' as a "chronic, severe, and disabling brain disorder that has affected people throughout history" (National Institute of Mental Health 2009:1), largely stems from years of psychiatric research on the prevalence, incidence and course of the diagnosis in westernised societies. Purcell et al. (2009:748) identify the incidence of 'schizophrenia' as "...about 1%". The premise for the 1% estimate stems from the work of Sartorius et al. (1986)\(^{15}\), however, McGrath et al (2004) contend the incidence of schizophrenia is not uniform and significant variations exist amongst populations. In a systematic review of 188 studies from 46 countries published between 1965–2002 McGrath et al (2004) identify variable incidences of 'schizophrenia' from 7.7 to 43.0 per 100,000. McGrath et al. (2008) record that the incidence of schizophrenia is higher in males than females, with a median rate ratio of 1.4:1.

Approximately 39,000 people in Ireland receive a diagnosis of 'schizophrenia', with 800 new diagnoses identified annually (Kelly et al. 2003). Over the years, a mistaken impression emerged that the prevalence of 'schizophrenia' in Ireland was considerably higher than international averages. In 1990, Nuallain et al reported the prevalence of schizophrenia, 'the proportion of persons in a population who have a particular disease or attribute at a specified point in time or over a specified period of time' (Dicker 1992), at 3.9 per 1000 of the population. This corresponded with prevalence figures recorded elsewhere in the world by McGrath et al. (2004). Nuallain et al (1990:136) maintain that historically, 60% of 'reported' prevalence and more than half of those in hospitals who had been given a diagnosis of 'schizophrenia' were no longer symptomatic. They suggest that the reason for the misconception was the continued detention in Irish psychiatric hospitals of people who did not score on symptom scales and who would otherwise be deemed as 'recovered cases' (Nuallain et al, 1990:136). In 2008, Behan et al estimated that the diagnosis of 'schizophrenia' in 2006, cost Ireland €460 million.

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\(^{15}\) The WHO 10-country study on the first contact incidence of schizophrenia.
'Schizophrenia' narratives in the context of biology

Andreasen (2011) notes that features of paranoia and 'schizophrenia'-like psychosis exist in accounts dating back to the first millennium BCE. Most writers in mental health, regard 'schizophrenia' as a psychiatric diagnosis, derived from *Dementia Praecox*, introduced by Emil Kraepelin's *'Lehrbuch der Psychiatrie'* of 1893 (Cantor et al. 1980, Tsuang et al. 1981, Leckman et al. 1982, Neighbors et al. 1989, Bentall 2003). Kraepelin united three existing conditions, catatonia, hebephrenia, and his own deteriorating 'dementia paranoia' under Benedict Morel's existing 'dementia praecox' term. The etymological roots of 'schizophrenia' derive from the Greek 'skhizein' meaning 'fragmenting or splitting' and 'phren' meaning 'mind'. Some people consider the term unfortunate, because of the confusion that it creates of a 'split personality' amongst the general public (Andreasen 2011). Originally, Kraepelin (1919) postulated that *Dementia Praecox* was a "metabolic disorder" characterised by two groups of 'malady', florid psychotic symptoms and emotional dullness, characterised by 'early onset, poor prognosis' with '36 "psychic" symptoms and 19 "bodily" or physical symptoms' (Mueser & Jeste 2008:3). Modern day psychiatrists now interpret these features as 'positive' and 'negative' symptoms (Arango & Carpenter 2011). Kraepelin held an unquestioning belief in a biological cause for *Dementia Praecox*, believing it a severe, unremitting degeneration, hence his use of the term *dementia*.

From its early origins, *'Dementia Praecox'* proved controversial. Bleuler (Bleuler 1911) observing remissions re-categorised *'Dementia Praecox'* as *'schizophrenia'*. However, Boyle (2002) considers Bleuler's re-categorisation as misconceived and futile. She considers that by adopting the *'Dementia Praecox'* construct, Bleuler never challenged the validity of the diagnosis. She considers that what we currently regard as schizophrenia is radically different from the original concept and that Kraepelin and Bleuler's likely misinterpreted the condition *Encephalitis Lethargica*, an atypical form of encephalitis, as *'schizophrenia'*. A viral condition rarely seen today, von Economo in 1917, reported it to be near epidemic proportions in the area of Europe at the time (Boyle 2002, Pilgrim 2007). He described *Encephalitis Lethargica* leaving some infected people in a post-viral state of statue-like motionlessness and speechlessness, exactly as those described in the *'catatonia'* sub-category of *'schizophrenia'*; interestingly also rarely witnessed today.

**The manifestations of the diagnosis of schizophrenia**

Modern psychiatric conceptions of the diagnosis of schizophrenia focus largely on the symptomatology of the diagnosis. Andreasen (2011) considers that for the majority of the 20th century, Bleuler’s (1911) perspectives on the central symptomatology of *'schizophrenia'* dominated diagnosis and clinical practices. This led to a strong emphasis being placed upon the presence of features of the diagnosis that were easier to recognise such as hallucination and delusion. She identifies that during the 1960s and 1970s in response to a drive for greater precision in diagnosis the emphasis in diagnosis shifted, under the influence of Kurt Schneider and his use of a phenomenological perspective. Schneider (1959) introduced the concept of *'first rank symptoms'* (Figure 1) and these ideas received wider acceptance when they were subsequently incorporated into the Present State Exam (Wing et al 1974), the first structured assessment interview of *'patients'* in psychiatry.
Table 1: Schneider's 'First Rank' Symptoms of Schizophrenia (1959)

Andreasen (1995) believes the presence of ‘schizophrenia’ compromises cognitive, intellectual and emotional functions with varied impact on psychosocial functioning. The established view of psychiatry is that ‘schizophrenia’ manifests in ‘natural dimensions’, those of ‘positive symptoms’ which sub-divide into two components - ‘psychotic’ and ‘disorganized dimensions’ with a third dimension, ‘negative components’ also present (Andreasen et al. 1995). Andreasen (2011:6) argues that the emphasis on ‘florid psychotic symptoms’ in Schneider’s (1959) ‘first rank’ criteria led to oversimplification and misunderstanding of the diagnosis and negative symptoms were deemphasised and neglected for many years. Arango & Carpenter (2011) accord Strauss et al. (1974) with the reintroduction of negative symptoms into the schizophrenia lexicon, their use having gone out of favour with the emphasis on Schneider’s first rank symptoms. Arango & Carpenter (2011) identify that the presence of what is termed negative symptoms may often predate the onset of positive symptoms. Andreasen (1983) categorised these negative symptoms as affective flattening or blunting, alogia, avolition or apathy, anhedonia or asociality and attention deficit (Figure 2).
Crow (1985), drawing heavily upon the presence of negative symptoms, put forward a two-syndrome concept of schizophrenia with a dual pathology. One, Type I, he believed was characterised by 'positive symptoms' and potentially reversible with neuroleptic medication and the other, Type II, featured a more progressive deterioration and a poorer long-term outcome. He associated the presence of negative symptoms with the Type II syndrome, to which he also accorded symptoms of cognitive impairment, abnormal involuntary movement and deterioration in behaviour. He presumed both forms had the same aetiology.

**Genetics and the diagnosis of 'schizophrenia'**

The role of genetics in the diagnosis of schizophrenia is fraught with claim and counter claim as to its importance. Early genetic research attempted to determine if 'schizophrenia' was either an inherited 'disorder' or an inherited 'predisposition' (Riley & Kendler 2011). Gottesman (1991) drawing together European studies conducted between 1921 and 1987, heralded the lifetime risk for 'schizophrenia' as tenfold higher in families with a pre-existing diagnosis when compared to the general population. However, Riley & Kendler (2011) consider this data to be unreliable and fraught with methodological problems. This is due to a lack of a standardised definition for 'schizophrenia', the inclusion of people with diagnoses other than schizophrenia, and no use of control groups. Tienari & Wynne (1994) believe the strongest support for a genetic cause comes from adoption studies. Kendler & Gruenberg (1984) report that in 1968 Seymour Kety published the first study of adoptive children of parents diagnosed with 'schizophrenia' that strongly supported a genetic link. In the study, children born to mothers diagnosed with 'schizophrenia', but subsequently brought up in adoptive families, demonstrated the same incidence as those reared by their natural mothers. Follow up research by Kendler et al. (1994), replicated the finding. Lichtenstein et al's (2009) research strengthens the case for a genetic link, drawing on data from the 9 million strong Swedish national
population dataset, finding comorbidity for the diagnosis amongst both adoptive and biological parents. However, the study also concludes both ‘schizophrenia’ and ‘bipolar disorder’ have partly shared ‘common genetic causes’ (Lichtenstein et al. 2009:238). The Kraepelian construct assumes that severe mental illnesses fall into discrete types such as ‘schizophrenia’ and ‘manic depression’, yet Lichtenstein et al. (2009), challenge this premise concluding that ‘schizophrenia’ and bipolar disorder share common genetic causes. Publication of the paper resulted in Owen & Craddock (2009:190) claiming that it was ‘time to face the future’ by abandoning the ‘reified’ construct.

In 2009, the International Schizophrenia Consortium (ISC) reported:

"...we provide molecular genetic evidence for a substantial polygenic component to the risk of 'schizophrenia' involving thousands of common alleles of very small effect. We show that this component also contributes to the risk of bipolar disorder, but not to several non-psychiatric diseases"

(Purcell et al. 2009:748).

Despite this, the exact case for genetic involvement remains unclear. Boyle (2002) identifies the central role of genetics in the perpetuation of the medical narrative and biological cause for ‘schizophrenia’. Regularly statements such as those above, emanate from genetic research teams aggrandising the latest round of outcomes from their work. Each new report, often drawing analogies to existing medical conditions such as that of O'Donovan & Owen (2011), who proclaim genetic research is ‘close’ to the gene, or handful of genes involved. They maintain such a hope supports the need for further genetic research, as it has the potential to identify ‘rare variants in genome sequencing’, which may translate into ‘clinical benefits’ (O'Donovan and Owen, 2011:285).

Riley & Kendler (2011:245) contend that thus far, the collective results of genetic studies conclude that ‘schizophrenia’ is ‘not completely attributable’ to genetic causes and that genetic studies have made ‘slow progress’. They see genetic involvement as possibly multiple genes at different locations spread across multiple chromosomes that do not follow regular Mendeleevian inheritance pathways and have only low effect on influencing the development of the diagnosis. Kirkbride et al. (2006) consider that the belief in a genetic cause for ‘schizophrenia’ is a misconception, stemming from the World Health Organisation 10-country research supposedly identifying a uniform incidence worldwide (Jablensky et al. 1992). Kirkbride et al. (2006) believe the epidemiological London ‘Aesop’ study refutes these findings. Kendler and Gardiner’s (1997) critique of adoption studies also concludes that environmental factors equally pertain to adoptive and non-adoptive families and these cannot be out ruled. Joseph & Leo (2006) also conclude that the plausibility of underlying environmental explanations and the inability to identify specific ‘schizophrenia’ genes mean that the case for genetic linkage is weaker than the figures lead people to believe. Fearon (2012) concludes that after twenty years of research, those pursuing a genetic cause are no closer to determining the genetic role. Ultimately, whilst consuming large proportions of research budgets, he concludes genetic effects will be insignificant when compared to neurodevelopment and the role of the environment.
Neurotransmitter hypotheses in 'schizophrenia'

As a biological theory, a belief in neurotransmitter involvement in 'schizophrenia' has assumed greater and lesser prominence at different times. Over the years, neurotransmitters were linked with the causation of 'schizophrenia', with Osmond & Smythies (1952), proposing a role for noradrenalin in 1952. Also, Woolley & Shaw (1954) noted elevated rates of serotonin (5-Hydroxy-Tryptamine) in schizophrenia. More recently, Van Kammen (1977) identified the role for γ-Amino Butyric acid (GABA), whilst Moghaddam et al. (1997) propose the Glutamate Hypothesis in an attempt to account for 'negative' symptoms of schizophrenia, which Weinberger (2007) considers as offering a 'new potential' for pharmacological treatment in 'schizophrenia' with a new class of anti-psychotic medication that might activate glutamate receptors. Latterly, Raedler et al. (2006) propose changes in cortical acetylcholine are the precursor for elevation in Dopamine levels in the Nucleus Accumbens.

Whitaker (2010) identifies the 'dopamine hypothesis' as the most widely accepted neurotransmitter theory. Howes & Kapur (2009) believe the earliest forms of the dopamine hypothesis developed prior to the advent of more sophisticated techniques in genetics, molecular biology, and imaging research and only focus on a narrow dopamine role. For many years, the sternest critique of neurotransmitter hypotheses came from the linkage of dopamine increases with the use of anti-psychotic medication. Seeman (1992) reports that in post-mortem studies, people diagnosed with 'schizophrenia' subsequently treated with antipsychotic medication consistently showed elevations in D2 receptors attributable to the treatment. This challenge was weakened when Abi-Dargham et al. (2009), for the first time reported the presence of dopaminergic pathology among people diagnosed with 'schizophrenia' prior to receiving treatment with antipsychotic medication. Yet Howes & Kapur (2009) still contend that the dopamine hypothesis requires reformulation, as it does not adequately account for the role of sociocultural factors. Abi-Dargham & Grace (2011) now regard Dopamine dysregulation as the fundamental element in the pathophysiology of 'schizophrenia'.

Alterations of brain structure

Johnstone et al. (1976) and Owens et al. (1985) suggested that 'schizophrenia' was a neurodegenerative disorder characterised by a decrease in grey matter and enlargement of the lateral and third ventricles creating the belief that these features were markers for 'schizophrenia'. Largely conducted on institutionalized people, Owens et al. (1985:27) believed the changes were unrelated to 'neuroleptics, insulin coma and electroconvulsive therapy' (p.27). Suddath et al. (1990), also reported these subtle abnormalities of cerebral anatomy in twins. However, Breggin (1993) challenges these 'degenerative' hypothesis, believing the changes are in fact attributable to treatment with anti-psychotic medication and electro-convulsive therapy.

*A serendipitous discovery credited to Carlsson and Lundquist (1963) identified that chlorpromazine (an early neuroleptic anti-psychotic) blocked Dopamine receptors in the brain. Seeman and Kapur (2000) credit Van Rossum's (1967) with putting forward the hypothesis of overactive dopamine pathways as the cause.*
Between 1988 to 2000, there was increased interest in the use of MRI in ‘schizophrenia’ (Shenton et al. 2001). Chakos et al. (1994) using scans pre- and post-medication introduction found structural changes in first episode ‘schizophrenia’ to the caudate nucleus attributable to neuroleptic medication use. They also found relationships between early anti-psychotic commencement and higher dosage usage with increased caudate volume. Later, both Madsen et al. (1998) and Gur et al. (1998) confirmed that cerebral cortex changes were directly related to neuroleptic medication dosage.

Altered neurodevelopment and the diagnosis of ‘schizophrenia’
Neurodevelopmental theories propose that ‘schizophrenia’ is the end stage of abnormal neurodevelopmental processes that begin years before the diagnosis emerges (Rapoport et al. 2012). Neurodevelopmental theories have become an ‘umbrella’ for a range of hypotheses encompassing prenatal and perinatal risk, infection, poor nutrition, famine, placental pathology, environmental interaction and disorder in cortical connectivity (Rapoport et al. 2012). Despite the link of structural abnormality identified earlier with pharmacological intervention, Fatemi & Folsom (2009) consider that since the late 1980s neurodevelopmental theory has regained popularity. This growth in popularity stems from neuroimaging studies, which they believe effectively, confirms a predisposition to developing schizophrenia.

Early brain insult and the diagnosis of ‘schizophrenia’
In the formulation of neurodevelopmental theories, psychiatrists also draw upon the large volumes of statistical data surrounding the incidence and prevalence of the diagnosis. Cannon et al. (2002) accord the first linking of birth complications to the diagnosis of ‘schizophrenia’ to Rosanoff et al in 1934. Since then a number of researchers have argued that obstetric complications are linked to an increased risk for ‘schizophrenia’ in later life (Lewis & Murray 1987, Murray et al. 1992, O'Callaghan et al. 1992, Dean et al. 2003). However, Cannon et al’s (2002) meta-analysis of population-based studies identified that when pooled together complications of pregnancy, abnormal foetal growth and complications of delivery only generate small effect sizes. They challenge the reliability of obstetric recording and its capacity to reflect aspects of the prenatal period. They consider the broad definitions of the obstetric complication compared in earlier studies as occurring at considerably higher rates in the general population to allow accurate interpretation. They conclude that using obstetric complication is ‘controversial’ and ‘...some way from indicating strong causality’ (Cannon et al, 2002:1087).

A second area of early insult proposes that neonatal and early childhood infections may account for the development of ‘schizophrenia’ (Hare 1979, O'Callaghan et al. 1991, Wright et al. 1993). In the analysis of the 1957 influenza outbreak in the UK, O'Callaghan et al. (1991) found an 88% increase in the average number of individuals who later developed a diagnosis of ‘schizophrenia’, in comparison to births occurring during the 2 previous and the 2 years after the outbreak. Another possible neurodevelopmental hypothesis suggests that a subgroup of those diagnosed with ‘schizophrenia’ may present as a consequence of an autoimmune process (Strous & Shoenfeld 2006). Yet another suggests that dysmorphogenesis or neurological soft
signs (NSS)\textsuperscript{17} (Waddington et al. 1999a, Waddington et al. 1999b) may be indicative of schizophrenia (Dazzan & Murray 2002, Bottmer et al. 2005), however, Dean et al. (2007) in their analysis could find no significant anomalies or signs to support the theory.

Cannabis and the diagnosis of 'schizophrenia'
Murray et al. (2007) contends that the effect of cannabis on the human psyche has been known for at least 4,000 years. Both Andréasson et al. (1987) and Henquet et al. (2005) identify a role for cannabis in the emergence of 'schizophrenia', as a possible trigger, recording a pooled odds ratio of 2 for Cannabis exposure. Murray et al. (2007) also identify a direct correlation: the greater the exposure to cannabis, the greater the risk for the diagnosis of 'schizophrenia' and where exposure occurred before age 15, Arseneault et al. (2002) identify a 4.5 greater odds ratio. The effect of cannabis in schizophrenia was the subject of a Cochrane Database systematic review in 2008 (Rathbone et al. 2008). The review sought to ascertain the effects of cannabis use or cannabis withdrawal/antagonists on people with schizophrenia or schizophrenia-like illnesses. The authors could find only one study, Edwards (2006), of sufficient quality to meet the criteria for inclusion. They conclude the 'the data is too limited to support, or refute, the use of cannabis/cannabinoid compounds' in people given a diagnosis with schizophrenia (p. 10).

'Schizophrenia' narratives in the context of child development and lived experiences
The second domain that psychiatric narrative locates the causation of 'schizophrenia' in is the context of the child's development and people's lived experience. These included psychoanalytic perspectives and theories of family dynamics, trauma, social adversity, urbanisation, ethnicity, and migration.

Psychodynamic Models of Schizophrenia
Michels (2003:9) sees the 'history of the relationship between psychoanalysis and schizophrenia as complex'. Lucas (2003:3)) considers that after a period of early optimism in using psychoanalysis as a treatment in schizophrenia 'interest has waned' with one area of exception, its use in first episode psychosis. He associates the fall off in interest as related to two factors, the growth in the perception that schizophrenia was a biological condition and the perception that outcomes of psychoanalysis in practice were poor.

Lucas (2003) accords the earliest use of psychoanalysis in schizophrenia to Freud, for whom schizophrenia represented the withdrawal of emotional involvement in objects and that the predominant symptoms of hearing voices or having strange thoughts represented an attempt to self-cure. However, Freud still maintained the presence of an underlying genetic or prenatal

\textsuperscript{17} Dysmorphogenesis is the presence of ill-shaped or malformed body structures. Neurological soft signs (NSS) are minor neurological signs indicating non-specific cerebral dysfunction. Those commonly tested for include:

- a) Stereognosis: recognising objects by touch
- b) Graphaesthesia: recognising writing on the skin
- c) Dysdiadochokinesis: impaired ability to perform rapid alternating movements
- d) Mirror movements: the presence of involuntary movements on one side of the body that mirror voluntary movement on the other side

Evaluating motor speed and the presence of involuntary movements may also be included in testing
insult (as proposed in some of today's neurodevelopmental theories) as a significant factor interfering with later brain development and contributing to the emergence of psychosis.

Willick (2001) suggests that after Freud, the British School of Object Relations theorists became the main advocates for the application of psychoanalysis to the diagnosis of schizophrenia. He identifies Object Relations Theory in schizophrenia as founded on three principles, firstly that schizophrenia is characterised by damage to the ego the first two years of life; that the root of injury to the ego is primarily related to inadequate caretaking; and, lastly in the majority of people diagnosed with schizophrenia there is no organic involvement.

As a proponent of object relations theory, Melanie Klein proposed a number of positions which she believed to be part of the normal developmental of the ego. Klein (1996) proposed two propositions in the psychical development of infants, the paranoid-schizoid and depressive processes. For Klein, these processes explained psychosis and the manic depressive group of illnesses. In the paranoid-schizoid process, Klein (1996) argued that schizophrenia resulted in a fragmentation of the person, this she associated with severe anxiety and loneliness, projective identification, and paranoid-schizoid narcissistic functioning.

Bion (1967), another proponent of object relations theory in schizophrenia, believed that there were both psychotic and non-psychotic elements to every person's personality. He supported Klein's perspective considering the actions of the person experiencing psychosis were based upon feelings of terror, and being all alone. Winnicott (1965) similarly believed that when people were faced with 'primitive agonies', psychosis could emerge as a defensive structure. As a result of object relations theory in schizophrenia theories, Kohut (2011) believes that psychoanalysis as a form of treatment, could represent a way of building bridges to support the fragmenting person.

'Schizophrenia' in the context of family causation

Sullivan (1924), was the first to advance the notion about an influence by mothers on the course of 'schizophrenia' in their children. Sullivan (1924) proposed that in schizophrenia there was a severe and dissociative warping of the person's personality and self-esteem. He was so taken with frequent presence of anxiety and terror in presentations that he placed infantile anxiety to the 'forefront of his etiological concepts' (Willick 2001).

Subsequently, two theories of family involvement in the causation of schizophrenia became prominent in psychiatric theory, that of the 'schizophrenogenic mother' (Fromm-Reichmann, 1948) and the 'anti-psychiatry' perspective of schizophrenia as a response to family tension and alienation (Laing & Esterson 1964). Cheek (1964:155) credits Fromm-Reichmann (1948) with the addition to the 'folklore of invidious womanhood' and the theory of the "schizophrenogenic mother" in the aetiology of 'schizophrenia'. Fromm-Reichmann (1948) identified strong conflicts in the family dynamics resulting in dependency and hostility. The theory proposed 'schizophrenia' was the product of a mother-son relationship defect; a by-product of 'over-anxious, obsessional, and domineering' mothering (Brown et al. 1962). From this point,
according to Lidz & Fleck (1965) deficient or abnormal intra-familial relationships became a focus for psychological research in the diagnosis of 'schizophrenia'. Cheek (1964) outlined schizophrenia as occurring when the maternal relationship became aloof. The mother, lacking empathy, was unable to connect with the child and consequently she resorted to engulfing and controlling the child in a need to complete her life. The theory also implicated the recessive role of the father in the relationship. The ensuing relationship, led to emotional and behavioural withdrawal on the child's part and ultimately psychosis.

The second prominent 'family' theory emerged from the anti-psychiatry movement of the 1960s. In 'Sanity, Madness and the Family', Laing & Esterson (1964) proposed that the family lay at the root of the diagnosis of schizophrenia. Their theory emphasised a sociological interpretation of the diagnosis, believing that 'schizophrenia' was a label and the causation was attributable to the family, rather than an individual. They saw the family as a miniature version of society, who victimised the person because of alienation and tension in the family. In an attempt to cope with the subsequent situation, the person evolved a 'special' pattern of 'schizophrenic' behaviour (Hamilton, 1980). This 'schizophrenic' response, Laing and Esterson conceived as the person embarking on a 'voyage into inner space'. Consequently, they considered the most appropriate therapeutic response was to support the person on this 'voyage', rather than attempting a cure (Crossley 1998).

McLean (1990) suggests that these 'blame-the-family' ideologies fell out of favour because of social pressure from family-oriented voluntary organisations, such as the National Alliance for Mental Illness (NAMI). Despite the demise of these theories, the family remains a central focus of current interventions theories. In 1962, Brown et al proposed '...the possibility of a causal relationship' between levels of emotion within the family and differences in the 'clinical condition at discharge' (p.68). From this work, the concept of 'expressed emotion' (EE) evolved, a qualitative expression to describe situations where people diagnosed with 'schizophrenia' living with relatives who were critical or over-involved in their care, became more prone to 'relapse' (Kuipers et al. 2002). With the emergence of the 'no blame' perspective, Anderson et al. (1980) published a theory on family work aimed at reducing the incidence of 'expressed emotion' that they described as 'psycho-educational'. Teaching the family skills on how to cope with the challenges of living with the person diagnosed with 'schizophrenia', they found marked reductions in the rates of relapse. Kavanagh (1992) argued that people diagnosed and living in a family environment with a high "expressed emotion" were 3.7 times more likely to relapse than low expressed emotion families. He concluded that the median relapse rate in high expressed emotion environments was 48%, compared with 21% in a low-EE environment. He also suggests that this translates into increases in voice hearing and strange thoughts. Today, psychiatry employs this concept of 'expressed emotion' as a factor in relapse of 'schizophrenia', with Marom et al. (2005) concluding that therapies aimed at lowering high expressed emotion in families warrant inclusion in treatment as a long-term prevention strategy.

'Schizophrenia' in the context of social adversity
Proponents of neurodevelopmental hypotheses point to the inability of biological theories to explain clustering of the diagnosis in particular circumstances independent of genetic and biochemical explanations. Here Rapoport et al. (2012) point to the role of the environment and adversity as significant in the development of a diagnosis of 'schizophrenia'. They believe
research on early social adversity accounts for the emergence of the diagnosis in later life. In a large Swedish population-based study, Wicks et al. (2005) explored five measures of childhood socio-economic adversity, namely living in a rented apartment, low parental socioeconomic position, single-parent household, unemployment and receiving benefits. The results showed that all five factors associated independently with an increased risk of 'schizophrenia', and where four or more indicators were present, the risk rose 2.7-fold. In a later study, Morgan et al (2007) showed that long-term childhood-parental separation before age 16 is associated with later development of 'schizophrenia'. When this factor is combined with the odds-ratio of ethnicity increases to 2.30 (Morgan et al. 2007).

Faris and Dunham noted as early as 1939 that significant neighbourhood variations in the incidence of schizophrenia existed in urbanised environments. Research that is more recent, suggests that being born or growing-up in an urban area is also a risk factor. In Denmark, Pedersen & Mortensen (2001) argue that risk increases with the number of years the person spends residing in urban areas before the age of 20. They identify people living the first 15 years of life in an urban environment as have a 2.75-fold greater relative risk. They also found this incidence increased to 4.6:1 among migrant groups. Gigerenzer (2009) advises on the deceptiveness of relative risk statistics, considering them as showing weak association in aggrandising terms and lacking transparency. He cautions on medicine’s use of these figures, believing their use causes unnecessary alarm amongst the public.

Bhugra & Jones (2001) point also to the presence of a link to social adversity in later life in the form of migration and ethnicity showing increased representation in the figures. This phenomenon is recorded across a diversity of cultures including Norwegian migrants to USA (Lazarus et al. 1963), Surinamese, Antilleans, Turks and Moroccans in Holland (Selten & Sijben 1994), East Africans in Sweden (Zolkowska et al. 2001), Greenlanders in Denmark (Cantor-Graae et al. 2003) and Black Caribbean in the UK (Kirkbride et al. 2006). Bhugra & Jones (2001) offer six possible explanations for higher rates of the diagnosis amongst migrant groups; namely, (i) the sending countries have higher underlying rates of the diagnosis, (ii) people who are predisposed to the diagnosis migrate or that (iii) the migratory process generates stress, which triggers the diagnosis. They also postulate that (iv) those subsequently diagnosed with ‘schizophrenia’ are misdiagnosed, (v) that mental health problems amongst the migrant community manifest with different symptom patterns and (vi) that those migrating are subject to living in environments with increased population show elevated rates of the diagnosis consequently. Despite the associations made to deprivation, urbanicity, and adversity the exact relationship between these factors and schizophrenia remains undetermined, although emerging theory queries if this relationship resides in the area of neuroplasticity, which I will discuss later.

'Schizophrenia' in the context of trauma
Largely arising from the domains of psychology and social psychiatry, researchers have sought to explore the psychological impact of trauma in the causation of the 'schizophrenia' diagnosis.

19 In contrast to Lichtenstein et al's 2009 work cited earlier, the 2005 study used a database sample of 2.1 million people.
20 Leff (2010:1) defines social psychiatry as 'concerned with the effects of the social environment on the mental health of the individual'. Closely linked with the use of cognitive intervention, the work of social
With these theories, there emerged a revision in thinking as to how cognition and education might influence the course and outcomes for people given the diagnosis and their families.

Wolpe (1958), highlighted that psychiatry believed at that time, there was no point in exploring the content of peoples’ hallucinations and delusions in the diagnosis of ‘schizophrenia’, with clinicians actively discouraged, for fear they would exacerbate symptoms and reinforce beliefs. This opinion still prevailed during my nursing education. In 1987, Patsy Hage, a Dutch woman diagnosed with ‘schizophrenia’, confronted her treating psychiatrist, Marius Romme. She felt her existing course of treatment lacked effectiveness and wished her ‘symptom’ of voice hearing to be taken seriously; the two embarked upon a research pathway to establish greater knowledge of voice hearers’ experiences. The outcome of the research profoundly affected Romme, who became an ardent campaigner for the abolition of the ‘schizophrenia’ diagnostic label. In his later work, Romme abandoned the term, focusing on the more general terminology of ‘psychosis’, concentrating on the problems that people encounter, those of voice hearing and strange thoughts.

Working with Sandra Escher, Romme developed an alternative model that considers hallucination or ‘voice hearing’ as a part of normal experiences, rather than seeing them as a pathological symptom of ‘schizophrenia’. The model holds that the symptom is not everything, that each experience has meaning to the person and is linked to events in their personal life, for which they are seeking meaning. The initial model, drawing on the outcome of the research, proposed three phases to the voice hearing experience, the startling phase which was usually characterised by sudden onset and fear, the organisation phase, where the person grew more accustom to the experience and could begin to interact and the stabilisation phase the person began to develop greater control (Romme & Escher 1989a). They hypothesised that it was necessary for psychiatry to accept the person’s experience as real and that it needed to understand the frame of reference of the person as a basis for working with them. They also felt it was beneficial for the person hearing voices to engage with the experience and begin to differentiate between the malevolent and beneficial voices and the effect they had on the person’s emotional state. Following on from the initial work they posited that it was not the presence of voice hearing that was problematical, because many people experienced the phenomenon, yet never received a diagnosis of ‘schizophrenia’ (Romme et al. 1992). Rather they believed the person’s capacity to cope with the experience that differentiates those who come to psychiatric services seeking help and are diagnosed from those who cope (Romme & Escher 2000). In 1992, they proposed an ‘emancipatory approach’ that advocated the use of coping strategies, four in particular that were successful; distraction, ignoring the voices, selective listening to the content and placing boundaries or limits on their activity. Romme and Escher’s (2002) later work explored the experience of children and voice hearing. In a group of children at an average age of 12.9, who experienced voice hearing, they found half did not receive mental health professional intervention and 60% experienced a discontinuation of the experience over a three year period. Here, they showed the severity of the experience, the
presence of anxiety and depression and the absence of triggers were aspects associated with
the continued presence of a voice hearing experience.

From Romme and Escher's (1989b) early research a pattern also emerged linking voice hearing
to traumatic experiences, with subsequent research revealing roles for post-traumatic stress
disorder (Wilcox et al. 1991), sexual abuse (Hammersley et al. 2003), bereavement (Escher et
al. 2004) and childhood trauma (Read et al. 2005) in the diagnosis. Recent research identifies
the mechanisms underlying voice hearing, believing the phenomenon occurs when the
individual mistakes inner speech for an external stimulus, whilst strange thoughts appear to be
the product of abnormal inferential processes (Bentall 2003). Romme and Escher's research
also confirmed that the relationship people had with their voices could change. This work led
to the development of the 'Hearing Voices Network' and the development of techniques that
later would provide a basis for cognitive behaviour therapy interventions for people diagnosed
with 'schizophrenia' (Chadwick & Birchwood 1994).

Grand 'Unified' Theories of 'Schizophrenia'

"It will be solved, undoubtedly before the twentieth century ends."

(Gottesman & Hanson 1982:18)

Kendell (2001:491) credits the Diagnostic and Statistical Manual IV (DSM-IV) with the
perpetuation of a 'reductionistic anachronism' of interpretation, portraying mental illness as
'mental' disorder as distinct from 'physical' conditions. He points to an existence of 'a
compelling literature' documenting that there is 'much 'physical' in 'mental disorders' and vice-
versa. In the treatment of schizophrenia periodically, theories emerge in psychiatry, which
attempt to unify existing theories of causation.

In 1967, Gottesman and Shields first hypothesised a 'multifactorial' polygenic (MFP) model for
'schizophrenia'. This model proposed that schizophrenia emerged in genetically 'loaded
families' in the presence of 'stress' (Gottesman and Shields, 1967:204). They hypothesised that
those most severely affected with 'schizophrenia' had more affected relatives. Fearon et al.
(2001) maintain that in a headlong rush to find the schizophrenia 'gene', psychiatry lost sight of
the possible interaction between genetic and environmental factors or 'stressors' identified by
Gottesman and Shields.

The most commonly identified theory uniting 'biological' perspectives with 'stressors' is the
Vulnerability Model of Schizophrenia proposed by Zubin & Spring (1977) (figure 3). The model
hypothesised that 'schizophrenia' resulted from a combination of factors. It identified a
threshold for 'schizophrenia' in all people proposing that when the person's ability to cope
exceeded the threshold, then schizophrenia occurred. They proposed vulnerability was
variable, the possible result of a combination of factors such as genetics, birth defects and
pregnancy complication.
In proposing a heuristic vulnerability/stress model of schizophrenic episodes, Nuechterlein & Dawson (1984) believed that stressors can result from both biological and psychosocial origins (figure 4). They identified a number of stressors, such as trauma, child abuse, bullying, failure, excessive challenges, and substance misuse. In their view, people with low vulnerability require high levels of stress before a problem might materialise; for those with high vulnerability, less stress might cause serious illness.
The model offered the potential for a new treatment paradigm when introduced, that combined a dual approach with pharmacological intervention decreasing a person’s vulnerabilities and cognitive interventions attempting to help people reframe their stressors. However, critique of the model centres upon its continued emphasis upon an underlying biological cause for the diagnosis and the lack of efficacy of anti-psychotic agents. If schizophrenia is a biological defect, the model does not explain why over one third of people diagnosed with ‘schizophrenia’ have a poor response to medication (Read et al. 2004).

Neuroplasticity in ‘schizophrenia’

Neurodevelopmental psychiatry’s strongest critique of the ‘biological’ perspective in schizophrenia stemmed from the inability of the latter to explain the role of social and psychological factors in the causation of schizophrenia. In response to this, the theory of ‘neuroplasticity’ has emerged as the most recent ‘narrative’ in ‘schizophrenia’, with a view to unifying ‘biological’ and ‘environmental’ perspectives. Nudo (2006) identifies that from as early as the mid-1800s, it was considered that the brain had the capacity to alter its functional activity, but that it is only in the past twenty years that ‘plasticity’ researchers demonstrated the phenomenon in animal and human subjects. For the majority of the twentieth century, neuroscience believed that as an organ, the brain remained irreversibly fixed after early childhood. ‘Plasticity’ proposes that the brain can alter its functional structure in response to experience (Nudo, 2006). The advent of a ‘plastic’ brain created new ways for psychiatry to accommodate both biological and experiential understandings of schizophrenia under a single unifying theory. Neuroplasticity attributes ‘schizophrenia’ to a faulty rewiring of developmental dopaminergic circuits occurring in the cortex of the brain under the influence of biological or environmental sources by altering connections between neurons, thereby altering the functioning of the brain (Lewis & González-Burgos 2007). Frost et al. (2004) consider that in ‘schizophrenia’, ‘plastic’ changes occur in developing neural circuitry at early ages and can remain asymptomatic until triggered by an event at a later stage of development, such as adolescent hormonal changes.

The foreshadowed problems of biological narrative

In positioning the schizophrenia narrative as a bodily malfunction, society places the ‘problems’ of ‘schizophrenia’ as amenable to psychiatric intervention. This ‘locatedness’ befits psychiatry, as a legitimising function for the ‘dividing practices’ it is empowered to do (Foucault 1982, Foucault 2008). However, the narrative affects people’s perceptions of identity, autonomy and the location of the recovery process. It also determines the treatment they receive and the subsequent outcomes of this treatment impact on the realities of their lives.

Both Roberts (2005) and Tucker (2011), document Foucault’s concern with ‘biopower’, manifest in the disciplinary power of psychiatry. Foucault sees disciplinary power as producing knowledge, and psychiatry using this knowledge as ‘legitimation’ for its actions, masquerading as ‘science’, becoming ‘enmeshed in the clash of petty dominations’ (Rabinow 1991:6). Jennings (2010:16-17) describes it thus:

“This power works like a fog; it is both intangible and blinding. If you can see it, you are diagnosable within its categories and may be singled out for special measures of control”.

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Harrington (2012) credits the rise of the bio-psychiatric perspective in American society and the attribution of the diagnosis to underlying genetic and biochemical causes. Serafini et al. (2011) consider that professionals using genetic explanations need to consider the potentially deterministic interpretations to which genetic theories lead. Simplistic interpretation of genetic causes lead families to believe that their children’s ‘affliction’ is the by-product of their forbearers weakness. As a fault of genetics, the problem is permanent, unalterable, and as such incurable. Fleming and Martin (2012:469) argue that the ‘widespread acceptance’ of the genetic approach is inconsistent with notions of recovery. They argue that results confirming a genetic linkage for schizophrenia are consistently overinflated. They cite flaws, both methodologically and in the statistical analyses used, considering the results of studies thus far have proven neither replicable nor consistent.

The permanent nature of dysfunction informed Kraepelin’s ‘dementia’ perspective, inevitable, un-reversible progression, a future summed up by the fatalistic ‘you’ll nevers’, communicated by ‘helpful’ professionals to prepare families’ expectations for a life with little chance of recovery (Perkins 2001); a permanent state, best managed by a psychiatrist using medication. Serafini et al. (2011) identify that people who believe genetic causation for schizophrenia have more stigmatised attitudes towards the diagnosis. Emerging theories of the diffusion of multiple genes spread diffusely throughout the population offers solace, serving to spread the blame throughout the population, with the ‘unfortunates unlucky that the diagnosis has darkened their door’; this outcome may seem more palatable to a distraught family receiving the diagnosis, but is of little consolation to the person diagnosed. In a similar vein, the narratives of brain abnormality, early brain trauma, and alterations to brain structure offer little hope to people diagnosed or their families. Yet, when biological psychiatry is confronted by the possibility of ‘recovery’, its response is that its ‘initial’ diagnosis was ‘erroneous’. As with genetic causation, throughout these narratives, despair is the order of the day, the concern of families becoming ‘who will care for my child when ‘I’ am gone?’

People’s responses to illness and how they view themselves, are governed by what they attribute to the illness. Biological psychiatry views ‘schizophrenia’ as a bodily illness. Accordingly, it expects the person to adopt a ‘sick’ role and conform to expectation as defined by the role (Parsons 1951). This allows individuals to withdraw from normal social function within society, but creates an expectation that the person needs care. Society places an obligation upon the individuals that they will follow the advice given by psychiatry with an implicit expectation that the person should undertake all psychiatry’s directions to enable them to return to health as soon as possible. However when people do not ‘conform’ to the expectations of the sick role by not following psychiatry’s direction, such as refusing medication their actions are interpreted as lacking of insight (Segall 1976).

As society permits the ‘ill’ person to withdraw from the demands of life it supports them; through its on-going endorsement of ‘illness’ essential to the receipt of ‘support’, psychiatry becomes the gatekeeper to the ‘essentials of life’ (finance, housing, treatment). The result of psychiatric intervention is a transformation of identity, with a new subject of identity emerging, in a life revolving around psychiatric action. Who the person’s understands him/herself to be, becomes tied to psychiatry’s diagnosis. Here too, the person plays an active part in self-formation, through a variety of “operations on [people’s] own bodies, on their own souls, on
their own thoughts, on their own conduct” (Rabinow 1991:11), thus generating the stigmatising (self) ‘schizophrenic’ perception.

In psychiatry’s attempts to forge a ‘docile body’ (Foucault 1991:136) ‘neurotransmitter’ involvement becomes a rationale for ‘biological’ intervention; medication can correct ‘imbalance’ and offer amelioration of the ‘distressing symptoms’. As a permanent biological imbalance, the ‘schizophrenic’ requires a treatment of indefinite duration. Biological psychiatry admits that its interventions are not yet fully refined and cause unpleasant adverse effects; however, it deems the risks associated with the diagnosis sufficient to require compliance with its treatment. Here it is prepared to effect ‘control’. Read et al. (2004) consider that biological psychiatry’s relationship with the pharmaceutical industry has a detrimental effect on the course of research in the diagnosis. ‘Big Pharma’s’ funding of psychiatry in large academic institutions, with its focus on genetic inheritance, molecular biology, neuro-transmitters and pharmacological intervention, they believe has limited the development of new approaches to care.

The foreshadowed problems of the child developmental and family narrative

Willick (2001) offers a strong critique of psychoanalytical theorising in schizophrenia. He urges caution regarding the validity of arguments pertaining to its use. He challenges the notion of the absence of organic underpinnings to schizophrenia drawing on the results of imaging studies using technologies unavailable at the time of the theories being formulated. Willick (2001) also draws upon the lack of any meaningful application of the theories to the real life ‘treatment’ of schizophrenia, commenting that only one of the object relations theorists, Rosenfield, has reported on treatment of people diagnosed with schizophrenia. He also identified that psychoanalytic theorists’ mixing of schizoid personality disorder with the schizophrenia diagnosis provided an erroneous perception of the usefulness of the theories. Willick (2001) concluded that the psychoanalytic perspective is a theory of its time and he calls for the revision of standpoints.

Believing the family causes schizophrenia is an unpalatable prospect for families and the acceptance of family narratives lies in the acceptability of the theories to the family itself. Laing and Esterson’s theories posed a direct challenge to mainstream psychiatry’s thinking in schizophrenia. Crossley (1998:879) identifies how Laing’s theories, finding support among ‘...bright young schizophrenics’, caused concern among fellow psychiatrists leading to ‘professional jealousy’. The noted psychiatrist Max Hamilton, who assumed responsibility for editing the then seminal textbook ‘Fish’s Schizophrenia’ in 1980, consigned Laing and Esterson’s theory of ‘schizophrenia’ to a postscript at the end of the volume. With scathing criticism, he closes the book with the dismissive words:

“...these theories became very fashionable in the late 1960s among radical youth and the intelligentsia of the media. It is generally true that an individual’s enthusiasm for Laing’s ideas is inversely proportional to his contact and experience with schizophrenics”

(Hamilton 1980:201)
Using Laing and Esterson’s theories and seeking a cause of attribution, the anger of those diagnosed turned to their families. Today family causation narratives have largely fallen out of favour, although they have metamorphosed into acceptable ways of working in ‘psychoeducation’ and ‘emotion’. Harrington (2012:1293) accords the ultimate demise of the family causation narratives to ‘the emergence of a new social reality in which mothers and families increasingly functioned as the long-term caregivers of their children affected by mental illness’. In social acceptability terms, ‘mothers’ could not be blamed if they were to be the ones to provide the care. McLean (1990) believes that the success of eradicating the ‘blame-the-family’ formulations of schizophrenia has come at the cost, namely the strengthening of biomedical narratives with families aligning with psychiatry, and enabling family members to become the eyes and ears of psychiatry within the home. In McLean’s (1990:969) view, this reinforces schizophrenia ‘as a disease of the brain’, narrowing perspectives and ignoring the role of family in shaping distress, thus hindering the potential for recovery. When Loren Mosher, a former president of the American Psychiatrists’ Association (APA) resigned from the APA in 1998, he sent an open letter to its members. In the letter, he stated that accepting "biologically based brain diseases" was “convenient for families and practitioners alike [providing] no fault insurance against personal responsibility”. He maintained that psychiatry’s alliance with families and the pharmaceutical industry created “a pro-neuroleptic drug and easy commitment-institutionalization agenda that violates the civil rights of their offspring”.

**Foreshadowed problems in ‘unifying’ narratives**

How we conceptualise and explain ‘illness’ needs to include variables over which a person can exercise a degree of control. Failure to do this, results in powerlessness and despondency. When Engel introduced the biopsychosocial perspective to psychiatry in 1977, the approach provided a potential for the interconnectedness of biological, psychological, and sociological spectrums. The model brought a dramatic shift in psychiatric thinking from a ‘disease’ perspective to recognising that psychological and social interventions, within the person’s remit to change, could influence the trajectory of conditions. Emerging in the same year, the ‘Vulnerability Model of Schizophrenia’ (Zubin & Spring 1977), also presented an amalgam of the biological, psychological and social domains as a constellation of factors converging in the manifestation of ‘schizophrenia. These models presented hope even when medication was completely ineffective (Holloway & Stein 2007).

Whilst seen to accommodate other domains with ‘medical approaches’, biopsychosocial perspectives continue to uphold the primacy of the biological basis for ‘schizophrenia’, and uphold the power dynamic of psychiatry. Butler et al. (2004) argue that biopsychosocial approaches still result in disappointing outcomes because their analytic philosophical traditions consider human experiences as fundamentally ‘bodily’ in origin. Although they stress the interrelatedness of biological, psychological and social, therapeutic interventions still retain an illness focus emphasising symptom reduction, relapse prevention and pharmacological intervention (Bebbington & Kuipers 2003, Holloway & Stein 2007).

Psychiatry places much faith in the unifying capacity of ‘neuroplasticity’. Fleming & Martin (2011) identify the potential of the narrative to free people given the diagnosis ‘from the implied pessimism of an unmodifiable genetic’ load, thus allowing professionals to work in a way that can ‘instil hope’. However, ‘neuroplasticity’ still presents problems as the model fails to account
adequately for two questions. Firstly, if biological insult occurs in the early years, why do symptoms not emerge until early adulthood? Similarly, if developmental impairment is present through physiological trauma, why does it only become manifest in some through the influence of life events, urbanisation, ethnicity, migration, and substance misuse?

**Foreshadowed problems arising from the validity and reliability of psychiatry’s ‘schizophrenia’ narrative**

Over the years, many writers and researchers challenged the validity and reliability of psychiatric diagnoses and the concept of ‘schizophrenia’. Bentall (2006) identifies three empirical tests for validity and reliability in psychiatric diagnosis (i) consensus on common causation (relationship to an agreed scientific model) (ii) the ability of diagnoses to respond to specific treatments and (iii) the ability to identify patients with common symptoms (inter-rater reliability). The diagnosis of schizophrenia, Bentall believes fails to satisfy these criteria; as illustrated in the preceding section on cause, there is no consensus on cause. In the second instance, Read et al. (2004) identify that although the anti-psychotic medications used to ‘treat’ the diagnosis of schizophrenia are more effective than placebo, their efficacy is very limited. They cite Arvantis and Miller’s (1997) study, which revealed only 29.7% of the 361 participants using the anti-psychotic medication showed a 40% or more decrease in symptoms using the Brief Psychiatric Rating Scale. In addition, as the following section will highlight, there is an absence of valid tests and measures of schizophrenia in interview schedules, which lead to inconsistent diagnoses.

Challenging the ‘sublime object of psychiatry’ and its diagnostic criteria

A significant challenge to the validity of the schizophrenia diagnosis came from the work of the ‘anti-psychiatry’ movement who viewed ‘schizophrenia’ as the ‘sublime object of psychiatry’ (Woods 2011). Woods (2011) uses the term to refer to the collective body of work exemplified by Thomas Szasz, Michel Foucault, Irving Goffman, Thomas Scheff and R. D. Laing in addition to the presence of countercultural movements in Europe and America which challenged the validity of psychiatry and psychoanalysis. All strongly rejected the ‘anti-psychiatry’ label applied to them. The movement is largely regarded as critical of mainstream psychiatry, but by no means provides a distinct interpretation of ‘schizophrenia’. The ‘anti-psychiatry’ perspective challenged the legitimacy of psychiatry in the presentation of psychiatric illness as biological entities, seeking to provide alternative explanations for understanding distress. Woods (2011) identifies three particular streams of thought on the subject of schizophrenia arising from the ‘anti-psychiatry’ perspective. The first, presented earlier in this thesis, centres on Laing’s (1971) ‘existential-phenomenological’ interpretations of schizophrenia, as a ‘mysterious’ but intelligible psychotic experience (Woods 2011:126). The second standpoint is that of Thomas Szasz (1978), who repudiating the diagnosis and rejecting the medical model perspective, lays the interpretation of deviant and distressed behaviours by the institution of psychiatry, as responsible for the construction of the ‘schizophrenia’ diagnosis, perpetuated to psychiatry’s own advantage. The third perspective on the diagnosis, Woods (2011:126) accords to both Foucault and Laing. Here, ‘schizophrenia’ is interpreted as an experience of the ‘sublime, the transcendent and the liberating’. Paradoxically in Woods’ eyes, this confirms psychiatry’s

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21 ‘Beautiful’ or ‘inspiring’
attitude of schizophrenia as a ‘sublime’ object. In the work of the ‘anti-psychiatry’ movement, the diagnosis of schizophrenia origins are located everywhere, an emphasis is placed on the ‘genesis’ within the world’s causes as a ‘micro-social crisis’, rather than its location within the individual (Woods 2011:130).

Influenced by the work of Laing, in 1973, in an attempt to establish whether psychiatry was able to distinguish between mental health and mental ill health, David Rosenhan, a psychologist, sent eight ‘pseudo-patients’ feigning a symptom of ‘schizophrenia’, to seek admittance to different American psychiatric hospitals. Rosenhan hoped to establish whether diagnoses such as ‘schizophrenia’ resided within the person or in the situations and contexts of those making the diagnosis (Hock 2002). Each ‘pseudo-patient’ on presentation reported they heard voices. The hospitals admitted all the ‘pseudo-patients’; seven received a diagnosis of ‘schizophrenia’. After admission, each pseudo-patient reverted to normal behaviour. Rosenhan (1973) believed the outcome demonstrated that psychiatry had difficulty distinguishing sanity from insanity, fundamentally questioning the validity of diagnoses like ‘schizophrenia’. Psychiatry questioned the validity of Rosenhan’s work, challenging him to repeat the experiment. Rosenhan agreed to a replication and over a 3-month period, staff identified 41 pseudo-patients. Rosenhan sent none, he concluded that the label of ‘schizophrenia’ became self-limiting and self-confirming; an opinion derived from ‘biases’ rather than ‘scientific’ fact.

Kutchins & Kirk (1999) also challenge the premise that psychiatry’s classifications operate from a basis founded in scientific findings. In ‘Making US Crazy’ (1999) they explore how in formulating the Diagnostic and Statistical Manual, psychiatry attempts to demonstrate its ability in determining normality from madness and what constitutes psychiatry’s legitimate domain. They argue that the bloating of the manual between versions II and III was designed to give an appearance of scientific validity, yet it was still possible for people to have a variety of wildly differing symptoms and acquire the same diagnosis. Kutchins & Kirk (1999) argue that rather than being based on empirical scientific data, diagnoses are a product of political compromise between vested interest groups representing professionals, the pharmaceutical industry, health insurance companies and government. They describe the behind the scenes machinations of diagnostic formulation and also highlight how ‘mental disorders’ are added and removed as a consequence of social action rather than scientific evidence. They use as examples of this the creation of Post-traumatic Stress Disorder (PTSD), the formulation that they perceive as created to validate the experiences of the Vietnam veterans, and the removal of homosexuality as a mental disorder precipitated by its own members ‘outing’. In defence of diagnosis formulation, Andreasen (2011) argues that the DSM was only ever intended to be a ‘consensus guideline’, not to be used as a textbook or definitive knowledge source. Illustrating schizophrenia’s lack of reliability, both Copeland et al. (1971) and Brockington (1992) found significant differences in diagnostic rates using UK and US diagnostic tests using the same cohort. Read (2004) also reports that it is possible to gather fifteen random people, with nothing in common in one place,

22 When assessing the same videotaped interviews, Copeland et al (1971) found 69% of American psychiatrists make ‘schizophrenia’ diagnoses, by comparison with only 2% of UK psychiatrists. Brockington (1992) found under prevailing American diagnostic criteria, 163 people would receive the ‘schizophrenia’ diagnosis, whilst only 65 would receive the diagnosis under the ICD-8 classification. In total, across a range of different diagnostic criteria using the same cohort he found the incidence varied between 163 and 19.
and for all fifteen to be diagnosed with 'schizophrenia'. In the only study of its kind Hunt et al. (1953) cited in Hill (1983), using data gathered during the U.S. Navy's screening programme during World War II, identified that psychiatrists agreed on only 37% of schizophrenia diagnoses when assessed on test-retest basis. Despite the revisions in diagnostic standards in the interim, Read et al. (2004) consider there is no reason to believe diagnostic practices have changed.

Schizophrenia in the context of a psychosis continuum model
The continuum hypothesis proposes an alternative model that 'schizophrenia' is not a discrete object, but that psychotic symptoms characteristic of the diagnosis are variants of normal experience located at the extreme end of a continuum (Bentall 2003). Largely based around the 'normalising' perspective, the basis for this understanding is the implicit assumption that that the 'first rank' symptoms (Schneider, 1959) people experience in psychosis, those of delusions and hallucinations are not inexorably linked to the presence of a disorder. Traditional psychiatric models place schizophrenia and its positive symptoms, as qualitative experiences that differentiate people who experience these psychotic symptoms from so called 'normal' members of society, however some argue this is a false representation (Claridge 1994, 1997, Van Os et al. 1998, Johns & van Os 2001, Bentall 2003). The assumption of a 'psychosis continuum' does not necessarily imply that there is a continuum of disorder (Johns & van Os 2001).

The continuum model holds that positive symptoms of psychosis are prevalent in the general population and explains this using a normalising perspective. Here a basic interpretation contends that hallucination can frequently be experienced by normal individuals under no special circumstances, and research identifies that more people experience hallucinations than seek treatment with medical or psychiatric services (Romme et al. 1992). The model also holds that normal individuals can hold overvalued and delusional ideas. Claridge (1997) argues that the psychiatric profession has invested little research effort in the notion of the continuum hypothesis and for the most part this model has resided in the domain of social psychiatry.

Is 'schizophrenia' a unitary concept?
Boyle (2002) believes that 'schizophrenia' is an umbrella term for a number of heterogeneous psychosis states of various origins and she challenges the validity of 'schizophrenia' as a 'unitary' construct, with a single origin. Rather, Boyle (2002) believes that the diagnosis of schizophrenia merely represents an amalgam of the personal beliefs of prominent users of diagnostic criteria for the manifestation of a clustering of the signs and symptoms that occur at a greater than chance level. She maintains it is a hypothetical or abstract construct; a social and professional stereotype formulated from reductionist statements and built from correlations drawn between assorted behaviours. She posits that what society identifies as a scientific construct, may be little more than a 'lay' concept accepted as science, because our sheer familiarity with the 'correlations' in behaviour, has blunted our ability to be critical when assessing the construct of 'schizophrenia' (Boyle, 2002:8).

In attempting to draw together the diverse strands of psychiatry's history, alternative theories of schizophrenia and aspects such as the effects of substances, Boyle (2002) shows 'schizophrenia' to be a deeply problematic concept, the perspective of a psychiatric enterprise

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on a phenomenon that is not well understood. She argues that it is a social construction, with no scientific evidence. Boyle (2002) considers that the encompassing of each new development into psychiatry’s ‘schizophrenia’ narrative reveals the fundamentally flawed nature of the construct, always offering the promise that in the next new ‘discovery’ the ‘truth’ of ‘schizophrenia’ is within its grasp. Both Boyle (2002) and Grant (2002) believe that psychiatry’s widely accepted interpretation of ‘schizophrenia’ acts to legitimate psychiatry’s function in a self-serving fashion. She believes schizophrenia to be a product of the psychiatric institution, enmeshed in language and the exercise of power. Boyle (2002) supports this perspective by drawing upon the analysis of delusions, which in many instances are ultimately shown to be reflective of the person’s engagement with the prevailing social structures and the manifestations of voice hearing or hallucination as a response to trauma. In response, she sees the role of intervention as helping those with these experiences understand the forces that fashion their experience and accordingly overcome them. In a way reflective of Foucault’s ‘psi-function’, Boyle (2002) sees the powers that sustain ‘schizophrenia’ extend beyond psychiatry, in how it is perpetuated by society, the media, popular culture, the needs of health professionals and caregivers, and people who come to rely on the diagnosis ‘schizophrenia’.

In the critiques of ‘schizophrenia’, some psychiatrists recognise the problem of society’s diminishing faith in its ability to solve both human and social problems. Although a Presidential Decree of 1990 promised within a decade that neuroscience and research on the human genome that would reveal the mysteries of conditions such as ‘schizophrenia’, this did not transpire and it was the discourse of recovery and the service user voice, which emerged from the decade. In this movement, driven by people no longer accepting of the paternalistic approaches of psychiatry, service users demand that engagement should be collaborative, and that psychiatry must move away from biomedical formulations to a more humanistic perspective (Bracken & Thomas 2001).

Attempts to dismantle the diagnosis
On the October 24 2006, a campaign began under the banner the ‘Campaign to Abolish the ‘Schizophrenia’ Label’ (CASL). Backed by many of the notable critics of the ‘schizophrenia’ diagnosis, the campaign focused on two key criticisms, (i) the diagnosis of ‘schizophrenia’ is unscientific, with unanswered questions regarding the reliability and validity of the diagnosis, (ii) the label of ‘schizophrenia’ is stigmatising and destroys the lives of those diagnosed. Japan replaced the diagnosis in 2002, with a new diagnostic category, that of "Integration Disorder", a syndrome based on a stress vulnerability framework, with a variety of causes, symptoms and outcomes (Sato 2006). This decision resulted from a perceived failure in the diagnostic process within the Japanese healthcare system to use the diagnosis of ‘schizophrenia’. Because of this failure, individuals did not receive information relating to the condition, its treatment, or outcomes with many living in services for years never knowing or understanding the reason for their stay in care. Many families too received no explanation or support. Bentall (2006:220) believes that ‘when all of the psychotic complaints have been explained, there will be no “schizophrenia” or ‘manic depression’ left’. Despite these arguments, some service users question the ‘foolishness’ of renaming ‘schizophrenia’, believing that replacing the label with another equally lacking validity, merely constitutes ‘replacing one stigmatizing label with another’ (Yates 2007).
The lived experience of ‘schizophrenia’ care

By contrast, with the plethora of research on cause and treatment, there are few explorations in research of the lives of people given the diagnosis. From the few studies identified, there is a portrayal of lives where stigma is an everyday facet of life. Hensley (2002) describes the initial experiences of schizophrenia in the sense of hopelessness and grief, from the consideration that all future life is lost and the great aspirations the person hold for his/her life extinguished. Jenkins & Carpenter-Song (2009) record 98% of people diagnosed with ‘schizophrenia’ encounter multiple forms of stigma permeating their life, irrespective of the improvements they make and despite recovery. McCann and Clarke’s (2004) exploration of nine young lives describes the perceived catastrophic effect of schizophrenia for those involved. Those diagnosed found ‘schizophrenia’ became a factor in their relationships. They also found medication altered their physical and mental identity, the changes becoming a source of shame, embarrassment and stigma. In their attempts to cope, Corin & Lauzon (1994) report people’s lives becoming dominated by personal detachment; resorting to social isolation and withdrawal, relocating themselves within their own world. Rudge & Morse (2001) in particular note how the adverse effects of neuroleptics, such as tardive dyskinesia alter bodily appearance, creating embarrassing behaviours that result in shame, and stigma. They describe how these patterns of behaviour also erode the support of friends and family members.

These experiences are not just those of the person but also of their relatives as Eakes (1995) reports that 80% of parents perceive the diagnosis as a grief-filled experience characterised by chronic sorrow as they face a lifelong responsibility of caregiving. The diagnosis becoming a ‘destructive force that radically transforms the normative family life trajectory’, the result of losing both ‘an imagined, idealized child and a transformation of the physically present child into a needy stranger’ Tuck et al. (1997:118).

Recovery and ‘schizophrenia’

“We now have the revolutionary insight that ‘schizophrenia’ – rather than causing an inevitable downhill deterioration – actually entails a slow uphill progression of recovery”

(Kruger 2000)

Mainstream psychiatry largely rejects the ‘postpsychiatry’ vision of recovery, regarding the criticism of their brethren from within as ‘negligent’ and contributing to the ‘progression’ of a ‘faulty’ agenda (Craddock et al. 2008)23. Contrary to Kraepelin’s original perspective, Ogawa et al. (1987) and Harding et al. (1987)24 challenge the myth of ‘schizophrenia’ as a spiralling

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23 In what they describe as a ‘wake-up call’, Craddock et al., (2008), in an open letter from thirty seven psychiatrists to the British Journal of Psychiatry, demand that psychiatry reverse the progression of the recovery agenda and reclaim its position as judge of the ‘patient role’.

24 Ogawa et al. (1987) report from 105 of 130 people receiving a diagnosis of ‘schizophrenia’ 27 years earlier, 31% were ‘recovered’ and 46% were ‘improved’. Harding et al. (1987) report five years after admission, 30% of people diagnosed with ‘schizophrenia’ never returned to hospital, 40% had one readmission and 30% were back in hospital. Twenty-five years after initial diagnosis, 50% lived in their own home, whilst 40% lived in supported settings.
degenerative diagnosis, believing a heterogeneous path for long-term outcomes and that those in ‘marginal or deteriorated states’ were the exception rather than the norm. Harrow & Jobe (2007) in a fifteen year follow up identify that not all people diagnosed with ‘schizophrenia’ require lifelong medication; they conclude people not receiving anti-psychotic medication experience intervals of recovery, have better functioning and more favourable outcomes when not using, than those who did.

**Foreshadowed problems in psychiatric nursing and its response to schizophrenia**

Thus far, psychiatric nursing research does not address its role and influence on people given a diagnosis of schizophrenia. Confusion and debate still surround the concept of ‘schizophrenia’ with nursing opinions divided on the role nurses should play (Gournay 1995, Barker et al. 1997, Keen 1999, Kelly & Gamble 2005, Kylma et al. 2006). Over the course of the 1990s, nursing’s understanding of ‘schizophrenia’ was at the core of debate on the very nature of psychiatric nursing theory; torn in a protracted, and as yet unresolved argument between polemic factions (Repper 2000). On one hand, Gournay argues that the lack of evidence supporting interpersonal approaches in ‘schizophrenia’ is indicative of the inherent weaknesses of the approaches and that greater precision in care is required, with nurses operating from practices with strong evidence bases, such as CBT. Yet, Barker et al. (1997) argue that the care arising from biomedical perspectives has led to nurses emphasising the importance of diagnosis and processing of care and that nursing needs to re-focus on the centrality of the person’s human problems and personal development. Collins & Cutcliffe (2003) consider that because of nurses’ desire to demonstrate their contribution to care, they have grown to prize interventions involving technical techniques such as CBT, but in doing so have neglected the person, leading to an increased ‘sense of hopelessness’. Since the ‘Gournay v Barker’ debates on the role of nursing in the diagnosis of schizophrenia, nursing has embraced a more recovery oriented approach, with the diffusion of recovery into practice beginning in the UK, Australia, New Zealand and Ireland (Mental Health Commission 2006, 2007a). Much of this growth can be seen as extending from the development of programmes such as the Thorn Initiative (Gamble 1995) and the COPE (Psychosocial Interventions for Psychosis (COPE) pathway) at the University of Manchester (Williams et al 2002). These approaches largely centre upon the use of structured psychosocial interventions which, NICE schizophrenia guidelines recommend as extremely effective and beneficial for people with psychosis intervention and they include cognitive behavioural and family-based approaches.

In their interactions with people, Magliano et al. (2004) report that nurses, emphasise the aspects of heredity, stress and family conflicts when discussing schizophrenia. Hewitt & Coffey (2005) consider that with the dominance of the biomedical model, nurses must adhere to these perspectives. However, Podvoll (1990) maintains that the pre-eminence of biological psychiatry has resulted in gross neglect for people with severe mental health problems such as ‘schizophrenia’. Likewise, Repper (2002) maintains that formulating schizophrenia as a ‘biological aberration’ invalidates the significance of therapeutic relationships, leading to nurses believing that psychotherapy has no role. Consequently, she believes nursing fails to formulate properly accounts of care and the relationships nurses have.
Hugo (2001) believes that professionals are less optimistic about the prognosis and long-term outcomes of ‘schizophrenia’ by comparison with members of the public. Maric et al. (2004) attributes this distortion of perception as a consequence of ‘Berkson bias’ (Berkson 1946), suggesting that in their protracted encounters with people given the diagnosis, mental health professionals formulate false perceptions of the diagnosis. Despite this, Caldwell & Jorm (2001:50) report that nurses are “more positive than any other professional group” provided people engage with services. Rogers & Kashima (1998) found that when working with ‘schizophrenia’, psychiatric nurses demonstrate consistency between their declared personal beliefs and their actions. They suggest nurses’ ability to control their automatic responses is due to the ‘targeted’ education they receive which allows them to maintain this consistency.

Foreshadowed problems emanating from the treatment of people diagnosed with ‘schizophrenia’ in Germany, 1934 -1945

‘All that is necessary for the triumph of evil is that good men do nothing’

(Burke 1909)

Whitaker (2002) records that science has perpetrated three centuries of horrific ‘cures’ on those diagnosed with schizophrenia with the likes of insulin coma, metrazol, electroconvulsive therapy and lobotomy all used to dim the functioning brain; brain damage inflicted as ‘miracle therapy’. Yet, no discussion on the diagnosis can neglect the treatment of schizophrenia in Germany between the years of 1934 and 1945. In the early 1930s, Strous (2010) maintains that German medicine abided by one of the most advanced and strict codes of ethics, yet despite this, “the greatest crime ever perpetrated on the sick” occurred (Haefner 2010:451). Torrey & Yolken (2010) estimate that between 220,000 and 269,500 people were either sterilised or killed in German psychiatric hospitals as a consequence of state policy. Haefner (2010) ascribes these actions to the ‘dictatorial edict’ of the Third Reich leadership. However in the context of Bauman’s "Modernity and the Holocaust", such simplistic conclusions cannot be granted to Haefner. Bauman (1989) considers that this responsibility is easy to deflect, that the atrocities of the Holocaust could not be perpetrated with such efficiency and exactitude without the complicity, knowledge and support of wider society. He considered the management of such an endeavour required the complex apparatus of modernity and the application and learning of science, at the zenith of its development embodied within German society. McFarland-Icke (1999) and Torrey & Yolken (2010) all identify that the techniques used in the genocide of 6 million people under National Socialism, had their origins and were honed in the extermination of the psychiatric population.

Attempts have been made to explain the actions of those involved in holocaust psychiatry. Amongst these are ‘Social Identity Theory’ and the ‘Bystander Effect’. Tajfel & Turner (1979) proposed Social Identity Theory as a way of explaining how a person’s sense of who they are, is

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25 Torrey and Yolken (2010) consider this figure is to be between 73% and 100% of those diagnosed with schizophrenia; the exact figure remains unknown.

26 Many of those concerned in the organisation and implementation of the programme, code named ‘Aktion T4’, moved to the management of the extermination camps at the outbreak of war.
based on their membership or affiliation to various groups such as social class, family or involvement with various sporting affiliates. He identified three processes involved in the construction of the group identity, categorization, social identification and social comparison. Social identity is seen as important to the person, becoming both a source of pride and serving to increase the person’s self-esteem, giving the person a sense of social identity, allowing them feel that they belong to a social world.

Tajfel & Turner (1979) believed the theory could be used to explain the phenomenon of racism in cultures and the justification for the actions of those involved in genocide. Becoming a vital part of the person’s identity, Tajfel & Turner (1979) argued that group members seek to heighten the status of the group to which they belong in order to increase their self-image. He proposed two group sets, an ‘in-group’ (us) and ‘out-group’ (them). The theory identifies that group members can raise their perception of self-image by discriminating against and being prejudiced about the ‘out-group’. Accordingly, people come to act in a divided the world broken into “them” and “us”, on the basis of the social groups we allocate people to. In this world, the ‘in-group’ will search for the negative aspects of the ‘out-group’, creating stereotypes and exaggerating the differences in others whilst at the same time seeking to enhance the similarities in the various facets of the ‘in-group’; all done in the pursuit of self-image enhancement.

As applied to Holocaust psychiatry, Latane & Darley (1969) attribute people’s inaction in crises to the ‘bystander effect’ involving the diffusion of responsibility and social influence as determining how people act. Here individuals monitor the behaviour of peers in assessing the appropriate response to determine how to act.

In a further development of these ideas, Social Impact theory (Latane 1981), also offers a way of accounting for people’s actions in participating in Holocaust events. Here, an explanation which can in part explain conformity is the “foot-in-the-door” process. This involves a graduated progressive commitment that often leads people to changes in beliefs and behaviour. Starting first with small involvement or favours, those concerned in the care in hospitals may have been motivated form a desire to be effective in carrying out ‘work’ or hoping for approval or promotion. As involvement escalated the motivation changed to conformity out of out of fear of punishment or survival. Key to people’s involvement in the extermination was a slow moral erosion that saw many of those involved lose their faith in the church. Many attempted to rationalize their behaviour, seeing the practice of euthanasia as acceptable or justifying their role as not being directly involved in killing, living separate lives between institution and home. As the individual’s involvement in the process deepened they no longer thought of the individual lives, but the effectiveness of the process.

With some notable exceptions, mental health professionals, doctors and nurses, implemented these policies and many of those concerned were eminent psychiatrists of the day. Operating under the programme ‘Aktion T4’, a systematic plan began in 1933 for the implementation of the ‘Law for the prevention of offspring with hereditary diseases’. It was conceived in the
eugenics principles widely subscribed to not just in Germany, but also in the United States and Great Britain. Under this law, people given the diagnosis of ‘schizophrenia’ were regarded as genetically ‘impure’, ‘incurable’, and ‘unworthy’ of life. Strous (2010) maintains that under the influence of propaganda, the well-educated, middle-class of German society widely accepted the theories. The support for the policy, he maintains, came from a psychiatry perplexed by its inability to provide a cure, despite it knowing the genetic premise was fundamentally flawed, as it knew well that the majority of new cases of ‘schizophrenia’ arose without the presence of the diagnosis in relatives. Furthermore, the reduced fertility of those given the diagnosis Strous (2010) contends was widely known in the medical community. However, McFarland-Icke (1999) disputes the role of eugenics in the nurses actions during the time, rather she attributes the actions of nurses to a society collective view for the needs of society to take precedent over those of the individual. Here the survival of those ‘productive’ in society assumed greater importance than those who had become a burden and were unlikely to contribute.

‘Those who cannot learn from history are doomed to repeat it.’

(Santayana 1980)

Science now overwhelmingly deplores the use of research conducted under the Nazi regime. Accordingly, psychiatry has avoided investigations surrounding the outcomes of schizophrenia sterilisation until relatively recently. Torrey & Yolken (2010) argue that the outcomes of the policy of sterilisation and killing of people diagnosed with schizophrenia form a legitimate data source, in the same way that research exploring the outcomes of ‘The Dutch Hunger Winter’ of 1944-1945 are used. They identify that because of the sterilisation and ‘euthanasia’ policies, the prevalence of the diagnosis following the war reduced by half. This reduction would be expected given the action, although if a genetic hypothesis held true perhaps lower figures would be expected. The reports of subsequent research however identify that in the years following the war, the incidence of the diagnosis doubled, however, following their analysis of Holocaust experiences, Torrey & Yolken (2010:31) conclude that:

‘...the cause of schizophrenia involves dozens, and perhaps hundreds, of genes ... carried by large numbers of people, most of whom never develop schizophrenia. It is possible that such genetic variations may cause disease only if they are activated by life experiences such as perinatal hypoxia, nutritional deficiency, infections, or other environmental factors’.

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27 The Eugenics movement as embodied in the research of eminent German psychiatrists Rudin and Kallmann attributed the development of schizophrenia to Mendelian recessive genes.
28 In 1907, the American state of Indiana instituted compulsory sterilisation and by 1928, 20 states had sterilisation laws. These were largely directed at the mentally ill (Torrey and Yolken 2010).
29 Illustrating the propaganda, Strous (2010) details the use of economic arguments to desensitise a society struggling under the burden of reparations to the plight of the mentally ill in how the cost of treatment for one individual over 22 years “would support 40 poor families with many children” (p.209)
30 Torrey and Yolken (2010) rationalise using the data on schizophrenia in research as an outcome of the event or policy, rather than data obtained as with specific research intent or purpose.
By contrast Strous (2010) concludes that the real lessons to be learned by psychiatry need to focus upon the ethical. He maintains that psychiatry ‘incorrectly engaged’ in philosophical constructs, investing its energy in theories of prevention rather than the morality of treatment (Strous 2010:209). Irrespective of the explanation for action, a fundamental fact remains. Psychiatric diagnostic theory reduced the person to the economics of his or her existence, allowing for a distorted image of the person, creating a barrier between ‘us’ and ‘them’, allowing the person diagnosed to be seen as ‘other’, and in the process ‘legitimately’ robbed of humanity; a person devoid of value and worth; “lives unworthy of living” (McFarland-Icke 1999:257). For those diagnosed with schizophrenia, as a product of psychiatric theory motivated by eugenics or perceived non-productivity, the simple outcome remains; those given a diagnosis of schizophrenia were deemed to not offer a contribution, all that was required for their expunging from society was a constellation of social circumstance.

The lessons of the treatment of schizophrenia in Germany between 1934 and 1945 illustrate how in modern times, just as in the seventeenth century, outside influences can affect science (Toulmin, 1992). Strous (2010) argues that ‘holocaust’ psychiatry allowed pressures from outside, in this instance political, to dictate treatment. In the reflections on treatment in schizophrenia in the globalised world constructed by ‘hypercapitalism’ (Klein 2007), psychiatry might now consider its relationship with multinational corporate bodies considering what outside influence may come to bear on those at the centre of care.

Conclusion

Medicine holds a hegemonic position in its power to identify ‘illness’ and control the ‘legitimated treatments’ to ‘cure’ or ‘control’ it (Zola 1972). Medical practitioners coming from within its institution effectively establish the grounds for discussing with other key institutions in society the management of what they define as ‘mental health’ using their terms of reference. Current mental health practices are a product of psychiatry, the premier institution that organises mental health within modernity. However, Engel (2002) accuses psychiatry of being preoccupied with its own professional identity and status. He considers medical practice as having undesirable effects in unnecessary hospitalisation, overuse of drugs and the inappropriate use of diagnostic tests. As psychiatry becomes a cultural, political and economic imperative, the biomedical perspective achieves the ‘status of dogma’; its attitudes and beliefs so ingrained that even those entering its ranks do so without questioning, consequently never questioning its foundations (Engel 2002:51).

In ‘Schizophrenia’, Boyle (2002) emphasizes that a historical analysis is vital to understand the problems of the diagnosis. She notes that as the depth of medical knowledge increases along the lines it chooses, it becomes more technical and less accessible, and thus the power of the medical narrative becomes greater, silencing critique. She calls for debate and open analysis on the topic encompassing varied perspectives.

Psychiatry has a great deal to say about ‘schizophrenia’. Entering the term into the ‘PubMed’ medical database on the 15th August 2012, identified 99,288 articles referring to the diagnosis, but we would do well to bear in mind the critiques of science. The purpose of this chapter, rather than attempt to resolve the rights and wrongs of particular theories and approaches to the diagnosis of ‘schizophrenia’, was to illustrate the foreshadowed problems that arise from
psychiatry's use of the label. Under the weight of the psychiatry's knowledge of 'schizophrenia', the volume of information itself becomes problematic, as 'schizophrenia' becomes inexplicable, a weight from under which we cannot move. Yet, despite all of this evidence, we are no wiser, and none of this information tells us how to engage with schizophrenia's human experience.

These foreshadowed problems show how confusion, ambiguity, and dilemmas result from these perspectives and create problems for clinicians as to which versions of psychiatric 'truth' they should impart to the people given the diagnosis, to those who care about them or the next generation of practitioners. I cannot resolve whether 'schizophrenia' is a unitary psychosis, as in the Neo-Kraepelinian construct to which the many of the proponents of neuroplastic models appear to be returning in recent years (Bentall 2006) or whether it is a behavioural manifestation, at whose root are multiple differing aetiologies, presenting in similar ways, as argued by Boyle (2002). Those advocating particular theories steadfastly retain canonical loyalty to those perspectives, maintaining that although there are flaws in their arguments, their perspective remains to a greater or lesser extent significant as a piece of the jigsaw and with just a few more pieces, it will be complete proving that they were correct all along.

In late modernity overshadowed by the 'risk society', the perception of needing aversive or preventative action consumes public sentiment. Today, the medical discourse of 'schizophrenia' holds sway, partly because of the power of the medical discourse, but chiefly because the treatment approaches offered in other domains, do not afford society the sense of security that it provides. The sociological perspective, whilst explaining the causation, exploring labelling and posing stern critiques on deviance perceptions, offers no acceptable intervention for people in whom the diagnosis manifests with dangerousness to self or others. Proponents of social psychiatry and psychological intervention concede that the interventions they champion are not a direct alternative to the pharmacology offered by bio-psychiatry. All approaches concede that sometimes there are no alternatives to society assuming control for the person and in most countries, society legislates for psychiatry to act in this role.

Allowing for the possibility of exception, the motivations of those working towards helping people given a diagnosis of 'schizophrenia' have at their root beneficence. Their conviction in these theories come from 'their' belief that what they do will help. At times in the heat of argument, this is forgotten. As Shorter (1997) attests, the advent of the psychiatric institution stems from society's attempted solution to the wretched existence of the mad; locked in the cellars, bound by chains. Yet, psychiatry's solution, in the guise of the 'hospital', falls victim to the exercise of power and the overwhelming force of its discourse. In psychiatry's defence, Shorter (1997) argues that all sciences need to emerge from their phases of 'quackery'. The current WHO standpoint on the diagnostic term, argues for the retention of the diagnosis. Acting as an anchor for those seeking to provide help to people who experience the phenomena associated with the diagnosis, irrespective of the stigmatising nature, it offers the opportunity to acknowledge willingness on the part of the people involved that they wish to help. Yet, empirically formulated in 'universal principles' and devoid of the 'emotional', psychiatric narratives fail to answer the tribulations of how to work effectively with those living with the diagnosis.
Chapter 3: Methodology

Introduction
I set out with an aim, to explore how nurses work with people with a psychiatric diagnosis of schizophrenia in contemporary practice. To do this, I decided upon an autoethnographic approach, returning to clinical practice and taking on the care of people given a psychiatric diagnosis of schizophrenia, using participant observation as the data collection method. This chapter explains my reasons for doing this, the philosophical perspectives and the methodological decision-making that informed those choices, and the practicalities of how I created the autoethnography.

The Social Positioning of the Research
Epistemologically, this study has its origins in the notions of interpretivism and constructionism, whereby we as individuals create meaning in our interactions. Meaning for a person depends on how he or she frames his or her understanding; how he or she reads the taking of a history of an episode. Two types of worlds exist, a natural and a social and there are fundamental differences between the natural world and its ‘reality’ and the social world’s ‘reality’. The ‘social world’ exists in cultures and time. Our understanding of the world or the ‘verstehen’ is something that requires interpretation. This study is firmly located in a social domain, an environment, where mental health problems, as highlighted in chapter two, are categorised and managed. When exploring the culture of a group, a key aspect of any research is that of ‘Ostranenie’ or ‘defamiliarisation’, the ability to make ‘strange of reality in order to recreate it anew’ (Bogdan 1990:116). To do this, methodologically, Crotty (1998) identifies ethnography as an ideal fit. Ethnography allows the researcher to study practices in a natural context and thus provide a “thick description” representative of holistic and participant-informed perspectives (Geertz 1973).

Choosing Ethnography
To acquire a depth of understanding, the radical critique of qualitative research challenges the sole reliance on interview data as a sound ‘source of witness information’ (Hammersley & Gomm 2008:112). To address this challenge, Hammersley & Gomm (2008) reinforce the need for triangulation of data from a wide range of sources, and in response to the critique they believe that ethnography can provide a wider range of data collection techniques. Begley (1996) proposed five methods of triangulation in research; data, investigator, theoretical, methodological, and unit of analysis. Denzin (1989b) on the other hand identifies three forms of data triangulation: time - data collection on a longitudinal basis, that of space – the use of different locales and finally triangulation by person/s – the use of varying levels of people involvement, as either individual, groups or collectives. Flick (2002) views the combination of multiple sources or approaches as providing additional rigour, breadth, complexity and richness to the results of a study.

In the modern world from the industrial revolution onwards, Williams (1981:165) posits that western culture has developed in ways that are less interpretable by qualitative perspectives and led to a reliance on ‘positive powerful techniques of analysis’ to explore lived experience.

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As a counter to this, Marcus (1986:170) considers that the textual construction, as created in an ethnography, acts as a 'crucible' for the integration of the macro into the micro, where the local accounts of encounters with impersonal systems are reconstituted into representations of culture in the larger order. Here the realist ethnography can become sensitive to the problems of culture through an analysis rooted in everyday life.

Hammersley (1983) describes ethnography as the most basic social research method, allowing the researcher to use a wide range of information sources to describe and throw light on research issue concerns. Baszanger & Dodier (2004) consider that using ethnography can fulfil three necessities associated with research in human activity; it provides an empirical basis for study, it allows the researcher to remain open to features that cannot be classified at the outset of the study, and it allows for an ability to ground results in the observations of the field. Ethnography places the researcher in the midst of what they wish to study, specifically here the challenges of psychiatric nursing practice working with schizophrenia, as examined in the experiences of nurses and people given a diagnosis of 'schizophrenia' and represented through observations of their accounts. Ethnography is an approach which has been used in mental health previously (Estroff 1981, Griffiths 1998). As advocated by Van Maanen (1988), the ethnographic approach allowed me to immerse myself in the culture of the psychiatric nurse. Two factors influenced the choice of methodology. Firstly, I believed that to develop an understanding of the role of psychiatric nurses working with people with a diagnosis of schizophrenia, it made sense for me to go to where psychiatric nurses worked, to observe or possibly experience the behaviour of the group. Participant observation is a key element of ethnography and central to this study, as I believe there is a need to understand how nurses working with people with a diagnosis of schizophrenia develop meaning through a social interaction, namely the interpersonal/therapeutic relationship. The second reason for choosing ethnography relates to the process of engaging with a person diagnosed with schizophrenia. This process can be especially difficult, one where time is important and where the establishment of trust is essential (Gamble & Brennan 2006). As interpersonal relationships and therapeutic engagement were central to nurses' work with people diagnosed with schizophrenia, only an ethnographic approach, with presence in the field over a prolonged period, would allow me to experience how psychiatric nurses establish trusting relationships with people diagnosed.

Ethnography is particularly effective when the desire is to illuminate experiences and to illustrate a way of life of groups and individuals, through the ability to reveal common values and ideas particular to the participants (Holloway & Wheeler 2002, Hammersley & Atkinson 2007). My choice rested upon this ability to provide critical exploration of small social units, such as those of community mental health teams, where we now provide the majority of our mental health care for people diagnosed with schizophrenia.

A key element in the creation of an ethnography is the development of mutuality (Hammersley & Atkinson 2007). A possible barrier in ethnographic research is suspicion and fear that the researcher may encounter in the role of participant-observer. The study consisted of immersion within a clinical environment to generate a representation of the role of psychiatric nurses working with those with a diagnosis of schizophrenia. The purpose was to explore nursing practices and to evaluate nursing care approaches in the care of schizophrenia. It was one,
grounded in real world experience, rather than one framed by experimental or prior conceptual considerations. My objective was to develop a critical understanding through participation in and observation of the ‘lives and conversations’ in which psychiatric nurses engage (Bourgois 2002). Those people diagnosed with schizophrenia and the people who work with them spend much of their lives on the margins of society by virtue of the stigma of mental illness. In these circumstances, as Bourgois (2002) identifies, the participant observation techniques of ethnography are better suited to documenting these lives. Prolonged contact with the field allowed me to establish long-term relationships with people that permitted me to ask provocative questions and then to consider thoughtful answers. Here the purpose was to acquire more than just the brief interludes as with an interview. My fieldwork involved sustained contact with people, the events surrounding their lives and the ‘institution’ of mental health service provision. In using participant-observation unlike in quantitative research, it allowed me to enter into the world of these people to establish the "background" of the environment, in peoples’ attitudes, beliefs, competences, and practices.

**Autoethnography**

Ethnography exists in a multitude of guises. Creswell (2007) and Reed-Danahay (1997) list among them feminist ethnography, confessional ethnography, dramatic ethnography, critical ethnography, life history, ethnographic novels, the visual ethnography, electronic media and autoethnography forms.

Identifying that autoethnography is now in use for more than 30 years amongst anthropologists, sociologists and literary critics, Reed-Danahay (1997) describes autoethnography as an individual researcher’s exploration of his or her own life and its context. Drawing from Geertz’s (2000) analogy, both Holman Jones (2005) and Ellis & Bochner (2005) describe autoethnography as a ‘blurred genre’, whilst Coffey (1999) criticises the autoethnographic method as self-indulgent and narcissistic. Spry (2001) identifies autoethnographic writing as resisting ‘grand theorising’ and the façade of objective research that decontextualizes subjects and searches for singular truth. There are a small number of autoethnographic autobiographic accounts in mental health nursing. However, so far, its use is limited to first-person accounts of personal mental health problems, such as those of Burnard (2007), who used the approach in analysing his experiences of treatment and Grant (2010) who describes his own experiences of alcoholism and the psychotherapy culture. This study used a different autoethnographic approach to explore the field in a way that an interview with a participant cannot fully explore. In my work, I used the autoethnographic approach to consider how a nurse makes decisions and how a nurse’s actions and those with whom they work influence the lives of people given the diagnosis of schizophrenia.

Chang (2008) sees much of the autoethnographic text as residing in the domain of Van Maanen’s (1988) confessional tale. These tales focus on “rare” and “memorable” experiences, which happen during the fieldwork (Van Maanen 1988:102). Despite the problems confessional tales pose, writers seek to reveal “personal biases, character flaws, or bad habits” to demystify the reader and allow them to identify with the text (Van Maanen 1988:78). Deck (1990) describes autoethnography as an indigenous form of ethnography authored by a native expert with first-hand knowledge of the culture, who can provide for an authoritative text. In her argument for legitimation of the personal account, Holman Jones (2005) speaks to the
transformative power of autoethnography and when experiencing Ronai’s (1995) ‘Multiple reflections of child sexual abuse: an argument for a layered account’ identifies how the text changed her beliefs about what scholarship should be. Holman Jones (2005:776) disputes whether the portrayal of ‘lifeworlds’ “that are partial, fragmented and constituted and mediated by language” ... can ever be viewed as “neutral, privileged, or in any way complete”. If we accept that accounts cannot be neutral or in any way complete, then as Toulmin (2002) advocates we must explore the relevance of context and time and explore the personal and mundane “details of experience” as a way to understand the relationships between individuals and the community in which they work or live. In an autoethnographic role, I felt I could overcome the problems that Deck (1990) identifies when seeking to conduct autoethnography, namely those of language, taking up residence in and acceptance by the community. The language of psychiatric nursing I knew as a registered psychiatric nurse of more than 30 years, with 21 years of clinical and 10 years teaching experience. I had experience both as a staff nurse and as a clinical nurse manager. When taking up residence in the field, I felt I had an advantage; although I never worked in the service chosen, I entered knowing most of the staff at the site; many I worked with in the past, others I trained with and some I taught as students. In addition, I knew the role of working in the community as I worked as a community psychiatric nurse for a period. I also worked in a day hospital and in therapy units.

Referring to the transformative potential of the autoethnographic process, Spry (2001) points to its capacity to create efficacy and healing in communal lives, as the process can reveal the seams and fractures of where problems lie and illuminate the contexts, thereby creating the spaces for resolution to occur. To establish the reality and culture of day-to-day practice working with people with the psychiatric diagnosis of schizophrenia, in January 2009, I joined the Community Mental Health Team (CMHT) working as a community psychiatric nurse. My desire to answer the question of the role of the psychiatric nurse working with people with a diagnosis of schizophrenia rested with my inability to reconcile the ambiguities in theory and practice that I encountered both as a clinician and as an academic. I struggled to establish a clear way of working which overcame those difficulties.

Ellis (2004) believes that there are a number of ways to conduct autoethnography. However, she considers that not everybody can write an autoethnographic account, as sometimes the probing required is more than people can manage. She considers that the autoethnographic style depends upon the individual’s status on a continuum of art and science. She sees the decision as important and feels that the writer must ask the question ‘what claims they wish to make’ as to following a traditional style, rule or method of ethnography.

Dealing with the emotional can often be tied in to dealing with difficulties in personal life. Ellis (2004) identifies involvement in psychotherapy as having encouraged people to be more emotional and allow them to discuss their vulnerabilities within autoethnography. Men, she identifies, often find the process more difficult as they find it harder to talk about their emotions and difficulties, being socialised into trying to maintain an appearance of control. Having personal experiences of managing reflective processes in education, I could identify with that sentiment.
Reflexivity

Subjectivity and bias are key facets for consideration in ethnography on the part of all contributors and especially on the part of the researcher, and it is therefore crucial to provide sufficient context for the reader to determine the researcher's voice and effect on the outcome of the research (Hammersley & Atkinson 2007). This thesis rests between the domains of realist and reflexive autoethnography (Ellis 2004). Reflexivity is the conscious experiencing of the self, as both researcher and participant. Reflexivity acknowledges the orientation of the researcher, his/her relationship to the data collected and the motivations in the representation of the data. Ellis & Bochner (1996) and Spry (2001) argue that reflexivity on the part of the autoethnographers causes readers to reflect critically upon how they interact with others, how they think of themselves and how they interact with other people.

Here, access to the local culture as participant provided me with an opportunity to use self-analysis and reflection on the beliefs, values, behaviour, character and practices encompassed within the role. My lived experience gained from working as a part of the team and engaging with people diagnosed with schizophrenia provided the first-hand interpretation of what was involved in the contemporary role of psychiatric nurse, whilst reflexivity placed my interpretation in the context of the influence I had on the people. Ellis (2004) believes that reflexivity is the key to the autoethnographic process, exposing thoughts and emotions, fears and exhilarations, attractions and resistance in the text. The researcher as subjective self, is recognised as integral to the creation of the autoethnographic text through recognising and interpreting the culture from his or her interactions with others (Spry 2001).

Methodological Assumptions: Sensitizing Concepts in Ethnography

Taylor (2004) advocates use of a theoretical framework in qualitative research to provide a systematic structure to a study and to ensure consistency in collection, data analysis, to add depth and rigour, and to enable the linking of subsequent findings to the development of knowledge. Field & Morse (1995:4) identify that in qualitative research, researchers often avoid the construction of a theoretical framework preferring to hold other work 'in abeyance'. Although acknowledging that sometimes ethnography is used to test theory, as notably in the work of Festinger et al. (1956), Hammersley and Atkinson (2007:24) argue against the use of theoretical frameworks and recommend the 'need to work the research problem up into a worthwhile and viable form...over the course of the whole project'. Here, they identify that it is 'not uncommon' for metamorphosis to occur in an ethnographic inquiry, whereby the substantive focus undergoes a dramatic change. An example of this is seen in the work of Shakespeare (1997) which, starting as an exploration of a housing cooperative, ultimately evolved to concentrate upon the verbal interactions in dementia between confused and normal people. Rather than working deductively from definitive concepts Blumer (1969:148) advocates the use of sensitizing concepts merely to suggest '...directions along which to look'. Two sensitising concepts underpin this study; they are symbolic interaction and street-level bureaucracy.
Symbolic interaction

Informed by interpretivism, the symbolic interactionist view serves as a ‘sensitizing concept’ within the study. Symbolic interaction is a ‘down to earth approach to the scientific study of human group life and conduct ... if it wishes to study religious cult behaviour it will go to actual religious cults and observe them carefully’ (Blumer 1969:47). Throughout the many variants of symbolic interaction to evolve, three fundamental premises are regarded as constant (Meltzer et al. 1975); firstly, people act and interact with each other based on the meaning and interpretation they establish from the situations they find themselves. Secondly, people derive meaning through their social interactions. Finally, the creation of meaning is a process based on and modified through the interpretations the person makes in his/her encounter with the world. People do not just react to situations; they interpret and define each other’s actions.

As a sensitizing concept in this study, symbolic interaction has meaning not just in the way that individual psychiatric nurses interact, or how their social group can influence their actions, but in the way that symbolic interaction can act as a lens in viewing the diagnosis of schizophrenia. When we consider schizophrenia using a psychiatric framework, in labelling systems such as ICD-10 or DSM-IV, the frameworks categorise schizophrenia as a ‘disorder’ of thought, language, meaning and perception; ‘disorder’ in the core considerations of symbolic interaction.

In these classifications of schizophrenia, psychiatrists interpret the person’s experience as ‘objective’ symptoms of an underlying disturbance. These symptoms are categorised according to their associations and allocated labels to differentiate distinct subsets of the ‘disorder’. Within the labelling system, schizophrenia is considered a form of ‘residual rule-breaking’ (Rosenberg 1984). Because of ‘rule-breaking’, psychiatry regards a person as violating social rules and accordingly categorises their behaviour as ‘deviant’. With ‘deviancy’, Durkheim argues that when individuals violate social mores, society’s reaction to this is to punish, reject and ostracise the person, resulting in stigma. Scheff’s Labelling Theory (1974) in turn suggests that should a former patient attempt to return to a more conventional role, he/she will be punished through rejection and stigmatization. Historically, this has happened to those diagnosed with schizophrenia.

A symbolic interactionist perspective of schizophrenia

“In order to communicate, according to Mead (1934), the individual must take the role of the other, place himself or herself in the other’s shoes, see matters from the other’s vantage point”.

(Rosenberg 1984:291)

Symbolic interactionism sees the individual as an acting organism (Blumer 1969). This individual acts within a society that is a network of intertwining socialisations, where the individual associates with some, or disassociates from others (Kantor 1964). Central to the individual’s functioning within this network are two key elements ‘role-making’ and ‘role-playing or role-taking’. A ‘role’ is the way a person behaves consistently or how he or she acts normally. Lauer and Handel (1977) believe that society can only exist if people are able to take roles. ‘Role-making’, is a creative process whereby individuals perform social roles by negotiating their behaviour. ‘Role-playing or role-taking’, is the behavioural responses
expected of individuals by others in society (Herman & Reynolds 1994). Role making and role taking offer both social and personal benefits.

In contrast to the labelling theory perspective, symbolic interaction differs in the way it interprets schizophrenia. At the micro-sociological level, it regards schizophrenia as an inability to take a ‘role’ or ‘role-taking failure’. For schizophrenia to exist two people are required, an ‘observer’ and an ‘actor’ (Rosenberg 1984). Within this relationship, when the external ‘observer’ cannot comprehend or place him/herself in mind or role of the ‘actor’ and understand his/her behaviour, he then judges the ‘actor’ as insane or disordered; essentially there is an inability to take that person’s ‘role’. The person's behaviour and thoughts are viewed as ‘insane’ through an external construction of the ‘observer’ (Rosenberg 1984). It is society that makes the determination that the person is insane, not the psychiatrist. The psychiatrist categorises the nature of the disorder.

The symbolic interactionist perspective provides a humanistic, holistic view of schizophrenia. If we view schizophrenia as an inability in ourselves to understand or place ourselves in the position of the ‘actor’, by virtue of an inability to take or identify with their role, then we cannot view the person in terms of deviancy. We are required to see him/her as a person who we cannot understand or with whom we cannot communicate. This is not to say that the symbolic interactionist perspective denies the thought disorder, altered perception and altered behaviour that occur within the diagnosis of schizophrenia. The symbolic interactionist perspective concurs with a notion of illness in schizophrenia and that intervention is required (Rosenberg 1984). However, the symbolic interactionist perspective of schizophrenia goes beyond that created by labelling theory, viewing schizophrenia as an inability to see the changes in communication that occur within the condition from the perspective of the ‘actor’ (Rosenberg 1984).

Symbolic interactionism offers scope for pluralistic interpretations of the ‘schizophrenia’ phenomenon. Sometimes used to explain the diagnosis, Zubin and Spring’s Stress-Vulnerability Model (1977) illustrates how this is possible. The symbolic interactionism’s perspective of schizophrenia is congruent with the interpretations of Zubin and Spring (1977). When introduced, the prevailing thought was that schizophrenia was not amenable to psychological intervention, and engagement with voices and thought content was considered detrimental and actively discouraged (Scharfetter 1980). Their model contests this older perspective and treatment targets a person’s vulnerabilities using pharmacological intervention, and attempts to reduce a person’s stressors through cognitive interventions.

The Stress-Vulnerability-Cognitive Model of Schizophrenia (Kuipers et al. 2006) framework (Fig. 5), an adaptation of Zubin and Spring’s model, evolved in response to limitations associated with treatment and the lack of efficacy of anti-psychotic agents (up to one third of people diagnosed with schizophrenia have a poor response to medication and negative symptoms do not respond well to medication). In addition, people using pharmacological interventions encounter extensive adverse effects. This revised model proposes that the experiences of people with a diagnosis of schizophrenia are a manifest, individual response to distress. It presupposes that all individuals have the potential to develop psychosis; however, some people are more susceptible by virtue of a greater vulnerability or a lower threshold to stressors. This
response is at the extreme end of normal human experience. The research identifies that significant numbers of the general population have anomalous experiences such as ‘hearing voices’ (hallucinate) or have ‘unusual beliefs’ (delusional/paranoid ideation), cardinal signs of schizophrenia, yet are not psychotic (Tien 1991, Honig et al. 1998). The model explains that individuals who are more vulnerable react to these anomalous experiences by believing that their experiences have their origin in external influences. In response, they isolate themselves; they possibly become hostile to others, and enter a world of psychosis.

In schizophrenia, the symbolic interactionist lens provides an understanding of the role of the therapist and treatment opportunities. Symbolic interaction concentrates on the relevance of ‘life in the present’ as influencing the condition and whilst not decrying the past, it believes that it is more fruitful to focus on current phenomena. The use of two reference points in its view can explain an individual’s behaviour, prevailing circumstances or the influences of the past. How we perceive things, depends on existence in the here and now, and our behaviours relate to present circumstances. However, a behavioural response is not the direct result of a stimulus, but it is the result of an individual’s response to the stimulus. This interpretation of the situation and the meaning that it affects in him or her governs the person’s response.

From the interactionist perspective an individual’s relationship with others becomes the basis for the development of his/her understanding of him/herself. The person diagnosed with schizophrenia develops a wealth of understandings and cognitions collected over a lifetime that are charged with emotion (Kantor 1964). Individuals act according to the circumstances in
which they find or define themselves. The symbolic interactionist perspective of schizophrenia considers that the person with the diagnosis can no longer function effectively for themselves and allows their prevailing anxieties to dictate how they the interpret events (Rosenberg 1984). In doing this they may construct meaning from whatever experience is at hand, potentially adding ‘any piece of symbolic driftwood’ to constructions (Fine 1993:76). Thus, the anomalous behaviour of the person, as constructions of meaning and understanding of the present, can be accounted for as responses to their experiences (Kantor 1964). This interpretation provides recourse for intervention in the diagnosis of schizophrenia by understanding the phenomena either experienced by the person within its current context or based on past events and the significance they bring to bear on current action.

Rosenberg (1984) identifies that a symbolic interactionist perspective brings an understanding of therapeutic intervention and the role of the therapist to the diagnosis and treatment of schizophrenia. While the symbolic interactionist framework provides for the use of medication, it also affords opportunities for other avenues of approach. In viewing the condition as a failure in role taking, our response can be to provide interventions where we try to understand, where we try to make the person understand or try to make the person understandable to others. The basis of interventions within the psychosocial framework, such as using cognitive behavioural therapy (Beck 1952), family intervention (Brown et al, 1962) and psycho-educative models (Anderson et al, 1980) become understandable as effective interventions working with the individual in trying to remove the patterns of behaviour that ‘others’ cannot understand, replacing it with ones that they can.

**Street-level bureaucracy**

The second sensitising concept was the theory of ‘street-level bureaucracy’ initially put forward by Michael Lipsky in 1980. The relevance of ‘street-level bureaucracy’ arose at an early stage in my work as I conducted ‘pilot interviews’ in preparation for the initial phase of the original study. At this time, I struggled to explain variances in individual nurses’ practices; even nurses working within the same community mental health team. My reading in trying to understand how these variances might arise, brought me to the work of Michael Lipsky, a professor of political science at Massachusetts Institute of Technology.

Lipsky (1980) maintained that public services are principally comprised of ‘street level bureaucrats’. He identified a number of largely front-line workers who shared commonalities, facing real-world challenges in their role within the services and he argued that because of the nature of services they deliver, they have to manage with limited resources. In researching the book, Lipsky (2010) found bureaucrats operated in face-to-face contact with service users and were invested with large degrees of autonomy in these interactions. He contended that the decisions that street-level bureaucrats make, the way they work and the routines they use, effectively create policy.

The notion of ‘street-level bureaucracy’ is not a new one to community mental health teams and like Wells (1997), I have come to a conclusion that psychiatric nurses working in community mental health teams function as ‘street-level bureaucrats’. As a sensitising concept in this study, ‘street-level bureaucracy’ has relevance not just in the context of organisation and policy, but using Lipsky’s (2010) analysis, in face-to-face interaction and applying their knowledge to
practice. The principles of Lipsky's thesis are relevant to how the psychiatric diagnosis of schizophrenia creates dilemmas for psychiatric nurses in practice, as they try to cope with contrasting perspectives on the diagnosis whilst managing high-pressure caseloads and balancing the goals of the organisation and the demands of acting autonomously and professionally. This arises from their need to cope with dilemmas posed by finite resources and high workloads. When trying to cope, Lipsky's (2010) analysis points to these efforts resulting in favouritism, stereotyping and the routinizing of practices that, place the needs of the bureaucrat or those of the agency first.

When people access the services of a street-level bureaucracy, Lipsky (2010) argues that they do so in a non-voluntary capacity. However, Lipsky explains that when people access services of street level bureaucracy, they do so, on a "volunteer" basis, because they lack choice, have "no income alternatives" or because of the service's monopolistic nature (Lipsky 2010:54). When taken in the context of mental health, this statement might appear specious where social control provisions generate coercive dimensions to care. However, the service user, irrespective of their voluntary or non-voluntary status under mental health legislation, is dependent on the agency; the agency's members are not subject to the service user's discipline.

Lipsky (2010) identifies three ways in which street-level bureaucracy contributes to ambiguity and conflict in practice. Firstly, this occurs when the beliefs professionals hold in relation to service users, clash with the outcomes of the bureaucracy. In the second instance, conflict occurs when their peers' perceptions of situations are at variance with their ideas. Thirdly, ambiguity occurs where the roles or influence of clients within the organisation interferes with the professional's routines. As applied to a mental health care setting, conflict exists between the social control/social engineering role and the challenge of recovery. A dilemma exists as to whether the role of street-level bureaucrats should be 'coercive or normative' (Lipsky 2010:49). While the service espouses client centeredness, it has to balance this with the coercion of individuals for the sake of compliance. Accordingly, street-level bureaucrats receive a large degree of leeway in how they manage and manipulate individuals in getting their compliance with approaches. Lipsky identifies that when presented with a challenge, street-level bureaucracy and by extension in organisations such as psychiatric nursing; frequently break down under the strain of the dilemmas of practice and use coercion against individual. The result is inevitable conflict between the client-focused professional norm and the dominant framework of the institution where the professional works (Lipsky 2010:44).

Every extension in the level of engagement with a service provided by a system increases the influence and control that the service has over an individual's life. Street-level bureaucrats, who have conflicting impressions of what the priorities are, and what will work best in relation to a person's condition, ensnare service users in their nets. In adopting standpoints, they justify their actions, citing action in the person's interest or alternatively in the interest of the public. Street-level bureaucrats in their actions, by increasing or decreasing the availability of information relating to care, regulate the distribution of knowledge and understanding. Where there is a non-voluntary relationship, the person has no alternative. They are 'controlled' within the encounter. Service users may fear punishment if they deviate from acceptable behaviour. If an individual refuses to interact, the service attributes the fault to the individual. Accordingly, street-level bureaucrats do not have to make conscious decisions that favour one client over
another; they simply selectively, perhaps unconsciously, inform clients how to use the system to the best advantage. In addition, they can coach selected clients in the way in which to behave in order to maximise the benefit. As a consequence, they respect fairness in decision-making and it is only information that is selectively distributed (Lipsky 2010:64).

In the interaction with a street-level bureaucracy, a process of 'social construction of a client' occurs (Lipsky 2010:59). There are four ways street-level bureaucrats control people (i) they distribute the benefits and administer the sanctions they are supposed to provide, (ii) they structure the content of interactions with clients (iii) they teach people how to behave as clients and (iv) they provide psychological rewards when clients enter into relationships with them. Consequently, although arriving as unique individuals, service users evolve to fit the standard definitions of their conditions.

The street-level bureaucratic relationship is also interdependent. The interdependency manifests in two guises, firstly without the client they have no service to deliver, and no justification for their role. In the second instance, without the client's interaction there is no feedback. Street-level workers greatly value expressions of gratitude and changes in behaviour as attributable to their work. No response to the benefits of their care equates to no affirmation of their value and worth.

Lipsky on the use of discretion
In their interactions with service users, Lipsky (2010) identifies that street-level bureaucrats become policymakers with significant impacts on the lives of individuals. Here, he cites the manner of how they implement policy at grass roots level. In their face-to-face interaction with service users, the individual street-level bureaucrat makes the decision on the relevancy of the various elements of policy that apply to the situation. Lipsky (2010) identifies that if aspects of policy conflict with their perception or analysis of a situation, they will selectively implement the elements they feel most appropriate, disregarding what will obstruct the smooth running of their job. In time, in the non-observance of implementation of policy, a new local policy becomes established as the organisation recognises the futility of trying to enforce the original policy. The street-level bureaucrats' reformulation comes to supersede original policy.

A key part of Lipsky's thesis centres on the use of discretion and power that 'street-level bureaucrats' have in their interactions with people and the use of 'control' as an essential functioning mechanism for street-level bureaucracy. It is this capacity for the use of discretion, which allows for the manipulation of policy identified earlier. Evans & Harris (2004) identify discretion as necessary for street-level bureaucrats to do their job as it permits freedom of movement to deal with uncertainty. Street-level bureaucrats often deal with cases and situations that are too complicated for reduction to programmed responses. In the working environment, they are often required to respond to the human dimension of situations and

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31 Lipsky (2010) provides the illustration of the policy on military veteran's access to outpatient healthcare in the US as an example of how grass roots implementation subsequently led to the replacing of policy. Following the implementation of regulations prohibiting outpatient treatment at no cost, doctors exploited a loophole which provided for care on a pre-admission basis. All patients requiring outpatient treatment were placed on a waiting list for admission, thereby granting them access to care on a pre-admission basis. As the conditions resolved with treatment cases were removed from the list. Authorities seeing the futility of trying to implement the policy embraced the practice and replace the policy.
expected to use discretion. Discretion presents an opportunity to intervene on behalf of clients and for discrimination to occur between one client and the next.

Evetts (2002) believes that discretion better represents professional judgment than autonomy. However, with considerable levels of discretion, a clear difficulty arises in how to manage individual cases. Lipsky (2010) views the exercise of discretion as problematic, because despite policies and claims of professionalism, they use favouritism toward some clients over others. Street-level bureaucrats exercise a high degree of discretion in a number of ways. In practical situations, they are forced to exercise discretion in dealing with the complexity of individual cases. Given the pressure on the resource of time, they are forced to develop shortcuts and simplifications to cope with the pressures and responsibilities they carry. Using discretion promotes their self-regard. It also encourages people to think that the street-level bureaucrat holds the key to their well-being and this maintains the legitimacy of the relationship between the two.

Lipsky (2010) argues that in the course of their interactions with people, street-level bureaucrats exercise ‘discretion’ during their face-to-face interactions, about which outside observers and other team members do not know the content. To this end, practitioners construct a model of the person with an individualised interpretation of the diagnosis. In this instance, psychiatric nurses can use this discretion in their interpretation of schizophrenia and the care they offer to people. Ultimately, the information provided in this use of discretion shapes the care. In many instances, this results in care centred on the production of social control: in their interactions, psychiatric nurses endeavour to create a person fashioned to fit their own work patterns and the prevailing service delivery model.

Resource management in street-level bureaucracy

A clear characteristic of street-level bureaucracy is that the demand for service tends to increase to meet the supply available. Evans (2011) identifies that Lipsky’s account of discretion centres on the way street-level bureaucrats control day-to-day resources and resist the control of management. Within their relationships, street-level bureaucrats deflect possible criticisms from service users ‘by appearing responsive to their needs’ even when they know that these needs cannot be met (Wells 1996:339). Street-level bureaucrats, Lipsky (2010) believes, try to find a balance between the requirements of the job and finding a degree of personal fulfilment and satisfaction. Part of the nature of street-level bureaucracies, however, is that work practices contribute to distortions in service ideals and put street-level bureaucrats in a position whereby they manipulate people’s expectations and the type of help that they feel that they should receive. Lipsky (2010) identifies three stressors for street-level bureaucrats (i) inadequate resources (ii) overload and (iii) role ambiguity. He also perceives street-level bureaucrats as lacking the personal resources to be able to manage work effectively, with service user stressors frequently dictating the manner of their response to situations. When crises emerge, street-level bureaucrats are frequently under pressure and have to make decisions in haste; thus even in low stress and low-pressure circumstances they still develop routines in response to the requirements of the job.

A further difficulty with street-level bureaucracy is a lack of predictability in the demand for the service. When a more active period emerges, in response, street-level bureaucrats manage the
amount of time spent with individual clients, with some people inevitably relegated to lower priority status. Lipsky (2010:38) argues that as pressure builds in relation to workload, individuals become insensitive to the human dimension of the job and respond in routine manners, becoming trapped in a 'cycle of mediocrity'.

**Lipsky on the use of routine**

Time is a valuable resource and street-level bureaucrats often assess costs using time. Lipsky (2010) contends that all street-level bureaucrats start off with good intentions to provide individualised care, however the combined pressures of large caseloads, high workload, high levels of client distress, few resources and the complexity of individuals with multiple problems challenge the street-level bureaucrat and defeat the aspirations that they have. In their attempts to cope with these demands, they resort to routine. Routines help when coping with the complexity of individuals, the numbers of caseloads and the actual resources that they have. They also train the clients to work with their ways. Interpreted from policy objectives, routines usually serve a significant role in rationing services. They assist in the control of clients, reduce the consequences of uncertainty and help workers manage resources economically and sensibly. While routines are orientated towards the objectives of the agency, workers also create them to assist with job requirements that may conflict with the agency demands. Wells (1996) argues that Community Mental Health Team (CMHT) members become assimilated into the CMHT culture out of self-interest and do not challenge routines for fear of isolation by their peers.

Street-level bureaucrats are obliged to make decisions based on available evidence rather than presumptions of proper determinations. Nurses and doctors are particularly important, as they have public trust to make significant decisions about individuals' welfare. They have been assigned profound responsibilities concerning the liberty of people, because society wishes safety from individuals they perceive as a risk, considering them as either incompetent or unable to act on their own best interests (Lipsky 2010:85). Using routines, results in street-level bureaucrats only identifying the key aspects of work, not spending time to discuss all the options. Routines do not just facilitate work; they determine outcomes and are subject to bias.

To summarise, Lipsky (2010) sees a dilemma at the heart of street-level bureaucracy; the street-level bureaucrat is supposed to assist people and make judgments on individual people who avail of their services, however organisational structures impede their ability to do this, making it impossible. As they attempt to surmount the obstacles to delivering an individualised service, they instead resort to adopting practices such as rationing resources, screening people who might benefit from their resources, and routinizing their interactions. By resorting to routine, services rather than being flexible and adaptive lose their responsiveness to the individual, and while occasionally this can benefit people, in the majority of situations inferior service results.

**Study Design**

This study was originally designed as an autoethnography in two phases. The first phase was planned as a series of elite interviews (Dexter 1970) with individuals who are/were in key positions to inform decisions on psychiatric nursing and mental healthcare policy. This process used an 'a priori' sample of 15 participants. The aim of the elite interviews was to establish participants' perceptions of the role and make comparisons with the 'life-world' experience of
clinicians in practice; to effectively represent ‘multiple voices’ and reflect a contrast to the practice component (Emerson et al., 2007). This group included people working in national mental health organizations, the mental health commission, governmental advisory capacities, psychiatric nursing advisors, administrators, mental health educators and writers on mental health nursing and schizophrenia. The majority of the group worked in the Irish mental healthcare sector.

Phase 2 of the study comprised ethnographic fieldwork. Here I became a member of a community mental health team. I worked as part of the team to gain an understanding of the reality & culture of day to day practice of the psychiatric nurse working with people with the medical diagnosis of schizophrenia. During this phase the study’s focus became me as the means of data gathering, using a position of being the insider/outsider in an auto-ethnography of care provision. Auto-ethnography is an increasingly well-utilised research tool associated with postmodern critiques in which the researcher uses his daily recordings and observations of himself/herself and of his/her own practice in order to ground an analysis in experience in a critically reflective manner. I employed the auto-ethnographic approach in order to build an understanding of the social self as psychiatric nurse working in this context of people with a medical diagnosis of schizophrenia.

The fieldwork used a both non-participant observation and participation observation. In the non-participant role I observed staff in their day to day work with service users and their supporters for a period of three months. The purpose of this phase was to allow me to develop a basic understanding of the team’s functioning and the interventions they used in care. In addition, I used a 9 month period of active participant observation when I undertook the care of service users to acquire a first-hand understanding of care. The original intention in planning a two phased approach was to draw comparison between the notionally ‘theoretical’ approaches the ‘expert’ panel might propose as against the reality of day to day clinical practice. As I began my initial analysis of the data, the volume of data and the capacity to produce a PhD thesis within the timeframe allotted for its completion led to my postponing the further analysis of the ‘elite’ interviews, to concentrate on the dilemmas that the fieldwork in clinical practice presented for me. It was in doing this that the core construct of dissonance emerged from the data. The timeline of these events and the conduct of the fieldwork is presented in Figure 6 below.

Doing Ethnographic Fieldwork
This section describes how I conducted the study. It details the way in which I selected the site, negotiated access to the area and how I accessed potential participants

Selecting a Research Setting
Marcus (1986) considers that an important question that must be answered is ‘why in this locale rather than any other?’ In constructing an ethnography of a post-modern world system, Marcus (1986) believes two possible approaches can be adopted in the creation of a text. The first involves the selection of ‘multiple, blindly independent locales’ (Marcus 1986:171) with an emergent text created as a sequential narrative that explores the consequences of both intended and unintended effects of actions. The second form stems from the exploration of a ‘strategically selected locale’ which provides the background for the creation of text that is
representative of the ‘cultural life within the bounded subject matter’ (Marcus 1986:172). I chose the latter approach.

The mental health system in Ireland is undergoing unprecedented change as a result of the publication of a new mental health strategy, a ‘Vision for Change’ (Government of Ireland 2006c). The community mental health team is the cornerstone of care in this vision. The site I chose, the Glenvilly CMHT, provided care across hospital, homecare, day-hospital, and community settings, representing closely the proposed model of care subscribed to in ‘A Vision for Change’. In a similar way to Maher and Dixon’s (1999) in their choice of Cabramatta as the case for study, the choice of this particular mental health team, represented a ‘symbolic location’ (Keith 1993) for the research. The team was the basis for an evaluation of a pilot programme of home-based care in Ireland (Gibbons & Cocoman 2006), and the area also came recommended through the regional Nurse Practice Development Coordinator, as an ‘exemplar’ in the care of schizophrenia.

An additional consideration in the site selection was the recommendation that I work with Angela, a clinical nurse specialist working within the Glenvilly team. This again came from the Nurse Practice Development Coordinator, who believed that if I needed an exemplar of a nurse in clinical practice, then I should consider Angela. The Assistant Director of Nursing, who ultimately would act as gatekeeper, independently shared the same opinion.

The voice of people with a psychiatric diagnosis of schizophrenia
Service user views are now considered an integral part of mental health research (Jackson & Stevenson 2000) and their views were considered essential to this study. This diversity in the voices heard within the study can minimise ‘ethnocentrism’ (Edensor 1998).
Stevenson (2000) consider that in evaluating psychiatric care, the inclusion of the views of service users is essential. I felt in developing this study that the inclusion of their perspectives would contribute much to the exploration.

Selecting Participants
Participants in this study came from diverse backgrounds consisting of people with experience of diagnosis of schizophrenia, psychiatric nurses and other mental health professionals. All of the participants in the study were over 18 years of age, could understand and speak English and gave informed consent.

The people with a diagnosis of schizophrenia, included male and female, attending the day hospital or outpatient services, from diverse age and socio-economic groups. All those participating received a diagnosis of schizophrenia in the ICD-10 criteria, F20-29. The consultant psychiatrist considered their appropriateness to participate based on their ability to provide consent rather than the level of symptom severity. Subsequent to application of this criterion, no person given a diagnosis of schizophrenia was excluded from potential participation on those grounds.

The health care staff: psychiatric nurses, doctors, social worker, occupational therapist and psychologist employed within the community mental health team, without exception agreed to participate. They had diverse age profiles and levels of experience. I will discuss the breakdown of the participants in more detail in the next chapter.

Access, Preparing and Informing People
Access is a key component of ethnographic work. In researching the role of the psychiatric nurse, establishing the views of service users and other disciplines affiliated to mental health, in addition to those of psychiatric nurses provides greater levels of validation to the outcomes. To this end, I sought to include all of the members of the multi-disciplinary team and service users in the research.

Preparing and informing staff
Sometimes in ethnography, a dilemma exists as to the ‘overt’ or ‘covert’ nature of the research (Hammersley & Atkinson 2007). My role in the study was ‘overt’ and I gave a full explanation of the nature and intent of the study to all potential participants. I made the request to access the site through the HSE mental health sector Director of Nursing. I met with him and the five assistant directors of nursing who, on review, agreed to recommend the proposal to the Area Administration Team who consisted of the Director of Nursing, Medical Director and Area Administrator. A condition of access was that I acquired indemnification insurance to practice in the service area. I received this through the HSE Estates Management section. With the permission of the Area Administration Team, the Assistant Director of Nursing for the area acted as gatekeeper for the study. He distributed letters of invitation and information leaflets to staff seeking their support for the study (Appendix 1 & 2). I met first with the CMHT’s consultant psychiatrist and then the nursing and other members of team, where I answered questions about the research. Every member of the team agreed to participate and provided written consent (Appendix 3).
Preparing and informing service users

Members of the CMHT identified potential service user participants. My initial contact with service users came through a gatekeeper, in this instance either the consultant psychiatrist or one of the clinical nurse specialists, who provided a letter of invitation and an information sheet (Appendix 4 & 5). My agreement was that the consultant psychiatrist would provide an opinion as to whether a person was able to make an informed choice about participating in research and whether participation might prove detrimental to the individual. In all but one instance, the team provided information on the study to people entering the service with a diagnosis in the schizophrenia spectrum. In the one instance, the CMHT felt that the assignment of a female nurse was more appropriate, given the service user’s experiences. The final decision to participate in the study rested with the individual service user and a consent form signed (Appendix 6).

Data Collection

A criticism of qualitative research is that increasingly it relies on interviews as the source of data collection (Gubrium & Holstein 2002). The study consisted of immersion within a clinical environment to generate a representation of the role of psychiatric nurses in schizophrenia. The collection of data used a combination of participant observation, interviews, and analysis of documentary materials in the clinical environment. Hammersley & Gomm (2008) reinforce the need for triangulation of data from a wide range of sources, in response to the critique they believe that ethnography can provide a wider range of data collection techniques. The primary data for the study comes from participant observation. By the end of the study, my notes extended across five note books. These were supplemented with notes taken electronically on my iPhone. I also drew from a number of additional data sources including semi-structured interview (detailed later), documentary evidence and my entries in case notes.

Participant Observation

Apparently, according to Reynolds & Metzer (1973), I belong to an 'unorthodox' or 'unconventional group' who favour participant observation. Both Emerson et al. (2007) and Hammersley & Atkinson (2007) regard participant observation as the core activity of ethnography, involving direct observation of participants in their natural environment. Participant observation occurs in the natural context of the research as actors who engage in interactions (Adler & Adler 1994). Participant observation follows the natural stream of everyday activity and draws the observer into an environment in all of its complexity. The choice of participant observation role is an essential decision process in developing an ethnography (Crang & Cook 2007). Adler & Adler (1994) describe three types of roles in participant observation, a ‘peripheral membership role’, an ‘active membership role’ and a ‘complete membership role’. The ‘complete membership role’ they identify as specifically related to autoethnographic research, is researchers immersing themselves in the field in order to grasp the depth of the subjectivity lived experience. Here, I adopted an active membership role (Adler & Adler 1994), enabling me to establish relationships with participants and to participate in activities with them, my involvement being ‘complete membership’.

When considering Gold’s (1958) framework, over the fifty weeks of the fieldwork, my roles comprised both ‘complete-observer’ and ‘complete-participant’. The fieldwork commenced
with a 12-week ‘complete-observer’ phase, where I observed the psychiatric nurses on the team in their day-to-day work with service users with a diagnosis of schizophrenia. These roles allowed me to ask questions and have people explain situations from their perspectives. During the initial phase as observer, I attended team meetings, shadowed the clinical nurse specialists in the clinics and on home visits and spent a week observing in the Day Hospital. In the second phase of thirty-eight weeks, to experience the autoethnographic perspective of care first-hand, I assumed the role of a researcher as ‘participant-as-observer’ (Gold, 1958), directly providing care to people given a psychiatric diagnosis of schizophrenia.

Flick (2002) identifies the main problem that researchers encounter in allowing them to remain in the field, is how they explain their role or presence. I explained my presence in the clinical environment to people as a post-graduate psychiatric nursing student, working in a caring capacity whilst researching how psychiatric nurses work. This was an entirely congruent and truthful explanation of my presence. Early in each encounter, either with a service user, family member or new staff member, I introduced my presence as a researcher into the conversation and where necessary explaining the objective of the research further. Working in this way provided me with an opportunity to experience approaches first hand through doing, in addition to observing. It did not present as an atypical situation in the area, as post-graduate psychiatric nursing students regularly visited in this capacity, as part of the Post-graduate Diploma in Severe and Enduring Mental Illness and whilst on placement there those students carried a caseload.

Writing field notes
Ellis (2004) believes that it is impossible to capture the truth of an experience: as always, what is told is a story of the past. She considers that true stories only happen in the present and that field notes are merely a selective story about what happened from an individual’s own particular point of view at a place and time, taken in the context for a particular purpose. If we accept this, then we must consider that every story is only partial, situated and a portrayal of what happened. Here it may only convey meaning, rather than exactness from the experience. Ellis (2004) believes that it is not essential to capture every single detail in what is written and certainly not the exact words. She also believes that when an event is emotionally evocative, people can remember and recall the details for long periods afterwards. In my accounts, I constructed the scenes and dialogue from the partial descriptions taken immediately following the events. Included were the details that I could recall, the majority of which I wrote on the day or the day after the event (Appendix 7). As Ellis (2004) describes, the development of the field notes happened over the course of time as I built them up in a number of layers. Initially, I prepared the field notes in a chronological way, detailing the event, trying to make exact sense of what happened and people’s responses to them. I then transposed the field notes into NVivo for initial analysis, to explore the themes that emerged in relation to the study. These themes fell into broad categories and around these broad categories, separating the chronologies out, I constructed the stories of the service users I worked with closely.

Semi-structured interviews
Interviews help us understand our working lives (Rubin & Rubin 2005) and from an ethnographic perspective, they give an opportunity to record, in participants' own words, their perceptions and insights into their culture and its context (Van Maanen 1988). In addition to participant observation, and to add diversity to the voices heard within the study, I used two informal semi-
structured interviews with people who used services (Appendix 8). Potential participants received a letter of introduction and an information sheet (Appendix 9 & 10). After a cooling off period an appointment was made to conduct the interview at a place of choosing of the person and written consent obtained (Appendix 11). Their views were essential to the study and I recorded and transcribed these interviews in full, incorporating them into the NVivo analysis.

**Documentary Evidence and Case Note Evaluation**

I kept a detailed diary of my fieldwork experiences incorporating observations, insights, concerns, reflections and accounts of decisions I made. To establish how nurses deliver, monitor and evaluate care, during the fieldwork, I gathered a range of documentary evidence in the form of clinical data from case notes on the way that care was delivered, monitored and evaluated. I also included organisational and systemic data that reflected the care on offer, numbers of service users accessing care, clinic through puts and service plans. The data sources included case notes, policies, mission statements, sample contracts of employment, job descriptions, assessment tools in use, memos, treatment care plans, information leaflets, guidelines, therapy programmes, pamphlets, books and booklets used in the service.

**Insider Research and the Problems of “Going Native”**

Identifying an increase in the number of “native”, “indigenous” or “insider” ethnographic studies conducted by researchers among their own groups and communities, Kanuha (2000) considers who conducts a study and how they do it to be of vital importance. In these circumstances, the aspects of insider and outsider roles and the problems of ‘going native’ take on added significance. In autoethnographic research associated with postmodern critiques of professional practice, the researcher becomes the data collection tool, whereby he or she uses daily recordings and observations of his/her own practice to ground an analysis in experience in a critically reflective manner (Ellis & Bochner 2003). As the data-gathering instrument, I was in the position of both insider and outsider in the provision of care. My role as researcher detached me from the team (outsider), but my role as community psychiatric nurse was integral to the provision of care (insider).

Hayano (1979) citing the early example of Frank Cushing’s ethnology of the Zuni Pueblo (1879-1882), identifies a problem with insider research and fieldworkers effectively "going native". Armstrong (1993) believes that "going native" is indicative of an over-familiarity that can develop between researcher and subjects, whilst Adler et al. (1986) associate "going native" with researchers losing detachment and objectivity. Fuller (1999:226) considers that where possible, researchers should attempt to consciously avoid being in a position of ‘going native’ citing the consequences as a ‘loss of validity, integrity, criticality, necessary distance, formality and, ultimately, reputation’. This renders the autoethnographic approach as inevitably problematical, as if we follow Van Maanen’s (1995) classifications of ethnography, the autoethnographer is in her or his fundamental origins “native”. As Denzin (1989a:34) notes, in autoethnography as the writer, I do not seek to present the account as an ‘objective outsider’. To establish the authentic experience of the dilemmas in practice by taking on the care of people diagnosed with schizophrenia, I effectively excluded my capacity to research in this way. That should not detract from the validity of the account, as I feel that only in this way can I accurately portray the authentic record of my reflections on care decisions.
Data Analysis: Turning the Field Notes into an Autoethnography

Hammersley & Atkinson (2007) believe that there is no single canonical way to approach ethnographic data analysis. In the analysis of autoethnographic field notes, Chang (2008) advises autoethnographers to remember that the ethnographic intent is to develop an understanding of the relationship of the self to the culture and others in the field that makes the autoethnography. She describes the analysis process as 'methodologically nebulous', needing researcher insight and the creative blending of 'multiple approaches', considering that it needs to be done with patience and is fraught with uncertainty. As Ellis notes, it is impossible to write autoethnography in a linear way and the data analysis mirrored this layered perspective. I ‘built up’ the contents in layers, writing additional detail, interweaving flashbacks of thoughts and feelings that developed in relation to the events. Often these reappeared in different contexts from my initial themes in analysis.

In the analysis, I largely followed the ‘grounded theorising’ perspective advocated by Hammersley & Atkinson (2007). This form of data analysis is based around ‘Grounded Theory’ (Glaser & Strauss 1967). The analysis followed an ‘iterative’ approach to the interpretation of data; submerging myself in the data, zooming back and forth considering the actions of myself and others, moving in and out of the ‘personal experience and social realm’, interweaving of the data collection, analysis, and interpretation, which led to the final autoethnography (Chang 2008). As noted earlier in Chang (2008), it did require patience. In the initial stages, having read this data several times, I transcribed the field notes, interview transcripts, notes on interviews, case note accounts, site documents, and additional data collected.

In the initial analysis, I uploaded the data into NVivo 8, a qualitative data analysis (QDA) computer software package produced by QSR International. NVivo is designed for working with rich text-based and/or multimedia information, allowing researchers to perform deep levels of analysis on data (Fielding 2007), where using thematic analysis of the content (Graneheim & Lundman 2003, Ellis 2004), The work in NVivo 8 represented only the initial stages of handling the data and was used for compiling the data to a central source and rudimentary thematic analysis that provided the precursor to the more detailed working of the data. In NVivo 8, I noted the patterns, connections, similarities and contrasting points in the data, drawing out the meaning units, creating condensed meaning units by interpreting the underlying meaning, then establishing sub-themes and themes using ‘node’ and finally ‘tree node’ structures. The outcome of this initial analysis is detailed in the figures 7-10 below, that show the explanations of the analysis modelled in the emerging themes.
Figure 7 What underpins our responses?

Figure 8 Street-level bureaucracy behaviours
I developed the writing over a number of stages, initially writing the thematic account as a formal report in qualitative thematic analysis. From this formalised report, I then transposed the account into the stories of the four central people given a psychiatric diagnosis of schizophrenia central to the ethnography, Andrzei, Aisling, Sarah and Greg, developing the themes at the cross-sections of their lives, where both I and other psychiatric nurses met. On each occasion of rewriting, I increased the layering of the account, incorporating emotional responses and placing the emerging ideas in the context. Having completed the stories, I then started to explore how psychiatric nurses affected their lives and my own reactions to the events surrounding their care. In the writing clear dilemmas in practice emerged, ultimately crystallising around the core construct of the autoethnography, the emergence of professional dissonance as an aspect in these peoples’ care and with this, how a psychiatric nurse attempts to cope with this dissonance when working as a part of a multidisciplinary team.
The quality of the ethnography: trying to apply the traditional criteria

Ellis (1997) considers that autoethnography needs to engage emotions to be effective. However Sparkes (2002) questions the reliance upon the use of ‘self’ as the sole data source, considering autoethnography at the margins of academic research because it is difficult to apply the traditional criteria for evaluating the quality of qualitative research. Spry (2001) believes that the hallmark of an effective ethnography is the quality of the writing, considering that a good autoethnography should be more than ‘a confessional tale’. Arguing that mediocre writing lacks the capacity to be transformative, she believes that it should be a ‘provocative weave of story and theory’ (Spry 2001:713). Although Garrett & Hodkinson (1999) suggest that it may not be appropriate to judge autoethnography using the traditional criteria for qualitative research, in this section, initially, I will attempt to place this study in the contexts of Lincoln and Guba’s (1985) established quality criteria of credibility, dependability, conformability and generalisability. However, having done so, I would like to offer the reader some additional criteria by which they might judge the quality of the piece.

Credibility

Credibility is the principal challenge that qualitative researchers face when undertaking a study and the assurance of credibility should be the most important guiding principle (Baxter and Eyles, 1997, Jackson 1997). Credibility in this study arises from the use of the multiple sources of data collection inherent in ethnographic methodology. Throughout the report, the truth-value is evident in the use of the participants’ own words in the report to substantiate claims made from the data.

A significant challenge to credibility is the ability to address the issue of possible researcher misinterpretation of the participants’ views (Schwandt, 2001), and show the accuracy of explanations or interpretations of phenomena (Janesick 2000). I am a psychiatric nurse who worked with people with a diagnosis of schizophrenia for over thirty years. For this study, I believed I was well placed to make an interpretation of the role of the nurse.

When compiling my field notes, I followed Denzin’s (1989a) guidance that observational records should contain explicit reference to participants, interactions, routines, rituals, temporal elements, interpretations and social organisation. The nature of my notes changed as the study progressed from early to later stages. My initial observations are generally descriptive and unfocused. As questions emerged, my later observations became more selective. Ethnographic interpretation relies principally on the researcher and the understanding he or she makes of the data. Authenticity in autoethnographic accounts is a vital component as the writer is in control of the account. To this end, I have included to the best of my ability as detailed and accurate accounts of the events from the fieldwork and my reactions to those events in as honest and forthright account as I can give. Detailed are my reflections and the responses of others in each instance. I have tried to acknowledge my biases, so the reader may consider these when reading the accounts.

Dependability

Kirk & Miller (1986) consider that dependability is equally as important as credibility when considering the quality of qualitative research. To demonstrate dependability, Schwandt (2001)
considers that the research process must be traceable, logical, and clearly documented from start to finish. Research texts recommend the use of an audit trail to confirm dependability (Lincoln & Guba 1985, Lincoln 1995, Holloway & Wheeler 2002, Cutcliffe & McKenna 2004, Gerrish & Lacey 2010). The thesis as presented stands as the audit trail and evidence of how I conducted the study. It documents in a systematic manner how I carried out the study from start to finish, the decisions I made during the analysis, the stages of the process and the theories emerging. The thesis include examples of the raw and coded data, fieldwork notes, and analytical memos of how and why phenomena were categorised and labelled in particular ways and shows how the unfolding interpretations were made from the data. Cutcliffe & McKenna (2004) consider that an audit trail can involve the participation of an external auditor who can monitor and question the researchers' decisions, data analysis process, and methodological process in this study. I conducted the data analysis under the guidance of PhD supervision at the School of Nursing and Midwifery, Trinity College Dublin.

**Confirmability**
Holloway (1997) describes confirmability as the degree to which the researcher handles the data objectively, whereby two or more people can arrive at the same conclusion. Adler & Adler (1994) propose a number of ways to enhance the validity of research using participant observation. The first form they recommend is the use of multiple observers; in this research, this was not possible as a solo project on very limited resources. The second form they identify is analytic induction by testing emergent propositions and searching for negative cases; this also was not suitable in this instance given the nature of access to the field. I was bound to the terms of providing care in the context of the community mental health team. The third method and the method chosen for this study, is the use of verisimilitude, the style of writing that draws the reader closely into the subject's world to feel the experiences palpably. When presented in this form, Atkinson (1990) identifies the emergence of authenticity to the reader in the vraisemblance of the text. I believe in presenting the findings that the reader will see the internal coherence and rational connectedness of the work from the quotes and field notes supplied. In the accounts presented, the reader can identify the plausibility of the findings and recognise in their own experiences in the factual nature of the text.

**Generalisability**
The generalisability of qualitative research findings is limited: Ellis (2004:195) argues that generalisability in autoethnography is 'always being tested... by readers as they determine if the story speaks to them about their experience or about the lives of others they know'. In this instance, I endeavour to provide 'thick description', as described by Geertz (1973), to assist readers in their interpretations. Another important consideration in the generalisability of this thesis is the importance of the chosen site. In this instance, the site was symbolic, representing as far as was possible to achieve, the blueprint for future care under the 'A Vision for Change' (Government of Ireland 2006c) policy document and as such is significant as it defines the parameters for the future work of psychiatric nurses in Ireland.

**An alternative standpoint on quality**
Given the opinions of Garrett & Hodkinson (1999) on the difficulty in applying standardised quality criteria to autoethnographic work, I would like to offer the reader an alternative
standpoint on how to consider the quality of this autoethnography. It derives from the formula presented by Holman Jones (2005) on what to look for or aspire to when assessing autoethnography. She offers six areas for consideration, which should emerge for a reader from the text:

1. **Participation as reciprocity**: how well does the work construct the participation between the author, performers and reader, marked by mutual responsibility and obligation?

2. **Partiality, reflexivity and citationality**: how well does the work present a partial and self-referential tale that connects with other stories, ideas, discourses and contexts as a means of creating a dialogue among authors, readers and subjects?

3. **Dialogue as a space of debate and negotiation**: how well does the work create a space for and engage in meaningful dialogue among different bodies, hearts and minds?

4. **Personal narrative storytelling has an obligation to critique**: how does the narrative and story enact an ethical obligation to comment on subject positions, acts and received notions of expertise and justice within and outside the work?

5. **Evocation and emotion as incitement to action**: how well does the work create a plausible and visceral ‘lifeworld’ and charged emotional atmosphere as an incitement to act within and outside the context of the work?

6. **Engaged embodiment as a condition for change**: how does the work place/embody/interrogate/intervene in experience in ways that make political action and change possible in and outside of the work?

(Holman Jones 2005:773)

However, I offer that only you, the reader, can assess the extent to which this work meets these criteria.

**Ethical Considerations**

The study was granted ethical approval by the Ethics Committee in the Faculty of Health Sciences in Trinity College Dublin. At the time, there was no local ethics committee at the site of the fieldwork and I negotiated access locally through the area management team. I based my application to the Ethics committee on the four primary ethical principles of beneficence, non-malfeasance, autonomy and justice (Childress & Beauchamp 2001, Murphy & Dingwall 2007), which then I attempted to abide by during the research and these aspects are discussed in depth. The faculty ethics committee regarded people with a medical diagnosis of schizophrenia as a vulnerable group, needing special provisions under the application of the principles. Curiously, separating these people from staff, means that staff participants, merit a lesser consideration than those for whom they care.
Politics and ethics influence the design implementation and outcomes of research (Punch 2005:24). Often in research authors have a tendency to describe the methodological conduct of the study as moot, however in reality, this is rarely the case. Punch (2005) believes what makes Whyte's 'Street Corner Society' stand out as a shining example of ethnography, are his "frankness and honesty" surrounding the serious mistakes he made. I could provide in this work, a description of a smooth running and ethically unambiguous study. However, to do this would be far from the "frankness and honesty" of Whyte's work.

Van Maanen (1988) and Crang & Cook (2007), highlight the political nature of ethnography, identifying that it is difficult for a researcher to be honest about the research experience. In some instances the publication of ethnographic research can lead to the threat of legal action and the rewriting of results based on legal advice (Punch 2005). There are few guidelines to assist researchers in overcoming the problems and dilemmas of research in the field. They may encounter situations, which often have to be resolved 'situationally' or even 'spontaneously' without chance for reflection (Punch 2005:23).

Researchers have to learn how to sustain a relationship when in the field (Van Maanen 1988). This requires building a relationship and trying to retain one's own emotional balance whilst not jeopardising acceptance by the group and consequently data collection. This places constraints on the ability to 'tell it like it is'. Punch (2005) likens involvement in the field to being 'on stage', the researcher plays a role, trying not to drop their professional visage, with resultant strain on the researcher. I struggled hard with this; working in the presence of many of my students in everyday practice, I felt the onerous responsibilities of being more chaste than 'Caesar's wife', seeking to model the attributes that I espoused in the classroom, yet knowing that displaying my true emotions would significantly limit my capacity to collect the data I required.

**Adhering to the primary principles**

This study was informed by four guiding ethical principles, beneficence, non-malfeasance, autonomy and justice. What follows are the explanations of my attempts to research ethically and in justice, treat all people to the same standard. In some situations, I found that I needed to modify my intended approach. As I will attempt to explain, I believe that in the course of action I took, I attempted to balance risks whilst maintaining the underlying ethical principles.

**Beneficence and non-malfeasance**
The principles of beneficence and non-malfeasance are tightly linked (Murphy & Dingwall 2007). Beneficence holds a researcher responsible for the physical, mental, and social well-being of the research participant in ensuring that benefits to research participants are maximised while holding risk to a minimum. Non-malfeasance is the commitment to avoid risks or reduce them as much as possible. Entering the field, accepting direct responsibility for providing care to people with a mental health problem, I abided by a simple guiding principle to my fieldwork; if I encountered a dilemma, my responsibility in care took precedence over my research need. This fact in part explains the length of time it took me to complete the research, I suspect to my supervisors' frustrations. To try to appreciate the complexity of the role, I agreed with the team to take not just people given a diagnosis of schizophrenia, but all diagnosis to provide as authentic an experience as possible. My decision to accept all referrals to the clinical nurse specialist care effectively meant that although I worked with fewer numbers of people than my
clinical nurse specialist colleagues, the level of input that I needed to provide was by proportion greater. This required more time than I anticipated, needing me to work more days in the field to ensure I met their care needs and left me less time to engage in adding depth and analysis to my field accounts.

As researcher engaging in a full participant role, as I have already commented, I brought a background of thirty years of knowledge and experience of mental health nursing. Prior to taking on the care of people with a diagnosis of schizophrenia, I spent a 12-week period in learning about the way in which the team functioned and how the nurses working on the team delivered care. By comparison with the standard practice in the area, which allowed a new staff member a week shadowing the person they intended replacing, this time afforded me a better opportunity to get to know service users and the members of the community mental health team. In a time of strained resources in Irish mental health care, the team felt that my access to the field brought benefits to the service. It strengthened the link with an academic partner, provided a resource to staff and students on the ground and elevated the status of research in the clinical practice area. As an unsalaried member of the team who accounted for his own expenses, I shared some of the workload at minimal cost to the service. When negotiating access, in the eyes of nursing administration and the team’s consultant psychiatrist, these aspects in part counterbalanced any potential risks from having on-going research occurring in the practice environment. In addition, during my time in the field, the team secured a research grant in excess of €150,000 from a foundation to develop a psycho-education package for people diagnosed with psychosis.

Murphy & Dingwall (2007) discuss the problems of beneficence and non-malfeasance in ethnography as extending beyond the aspects of immediate risk identified above to more subtle areas of problems which can arise from involvement with researchers in ethnography. Two in particular I identified as central to my involvement with service users in the study, those surrounding (i) the feelings of loss and separation surrounding the ending of my relationships on leaving the field and (ii) the problem that 'consciousness raising' of alternative approaches to care might bring.

From the outset of the study, I attempted to put plans in place to manage the potential for loss and separation on leaving the field. When entering the relationship with a service user, I clearly identified my role within the community mental health team as that of a researcher. I gave a clear expectation that the relationship would be a time-limited relationship, and ultimately I would leave the service at a finite point. For many service users, this was not problematic as frequent changes in contact with nurses in the service were commonplace. Each service user that I worked with had a designated key worker who would provide care in my absence, and who would assume care responsibilities on my departure from the service. When reaching my decision to leave the field, I allowed for a three-week transition period during which I transferred to care to the designated key worker.

The problem of 'consciousness raising' was one over which I had little control. As will be seen from the emergent data analysis, each nurse that the service user encounters brings her own beliefs and values system to the application of care. In this instance, I believe it is impossible to manage inadvertent 'consciousness raising' in mental health care. As an experienced nurse, I
have tried to practice from a strong evidence base, in doing this I have tried to remain true to these convictions.

A significant problem for people who were the subject of ethnographic research stems not from the conduct of the research itself but from the publication of the results of the research. Murphy & Dingwall (2007) discuss this in the context of the temporal projection of risk. They described the problems of the sensitivity of individuals and the power of ethnographic research to offend. It is very difficult for researchers to know what will or not offend for often it is not just in what is published but also what is left out where the problems arise. I entered the field with very overt intentions; when negotiating my entry I was clear in my declaration to potential participants that I would be honest to the experiences I witnessed, even if this entailed a warts and all description. People were free to decline participation; none did. In autoethnography, it must be accepted that what is provided in the final account is just one interpretation of the data, in this instance my interpretation. It is not my intention to deceive or misrepresent people in this account, it is just the interpretation taken from my perspective. The reader must judge, and I must be judged, on the balance of that interpretation.

Autonomy
Participants in research have the right to self-determination and full disclosure. The central component of autonomy is respect for persons and when conducting research, it is a moral requirement to both acknowledge the individual’s autonomy, and to protect those with diminished autonomy. At all stages of the study, I obtained either written or process consent from participants, depending on their involvement in the study. Obtaining an informed consent through accurate information provision, ensuring comprehension of the information and guaranteeing voluntariness of participation are the manners in which I attempted to ensure this. For the most part, I obtained written consent from participants in the study; however even in this, I must acknowledge the problems of signed consent. Receiving written consent is no guarantee that a person fully understood the nature of what they consented to (Streubert 2011) and throughout the research I used process consent, periodically checking with people as to their happiness to remain in the study (Usher & Arthur 1998).

For service users in mental health, the provision of written consent can present problems of confidentiality and lead to potential participants refusing to be involved in research. Kaminsky et al. (2003) exploring the willingness of people diagnosed with ‘schizophrenia’ to participate in research comments on the manner the consent process acts as a deterrent, in particular citing the experiences of African Americans. They identify distrust of the medical establishment, poor knowledge of research, and misconceptions that informed consent equated with signing away a person’s rights as barriers to participation.

My research was not covert; all participants were free to decide on their involvement. All of the service users who ultimately allowed me to partake in their care had an option for care provision from one of the other clinical nurse specialists, had they so desired, without any negative consequence in terms of care they would receive. During the observation phase, when service users were present, the nurse working with them explained my presence and requested their permission for me to stay. On two occasions, service users requested I leave. On two other occasions, when visiting people with a diagnosis of schizophrenia in their home, the clinical
nurse specialist that I shadowed felt that the person might object to my presence and in these instances, I did not enter their home.

In line with Jackson and Stevenson's (2000) opinion on service user participation in mental health research, I included people with a diagnosis of schizophrenia as participants in the study. In this category, I selected only people considered capable of providing consent. As a part of ethical approval, the team's consultant psychiatrist provided an opinion as to whether the person was appropriate for participation in the study. A gatekeeper provided details of the study, and only when they acknowledged their interest did I initiate contact. Following the introduction by the gatekeeper, I gave an individual information session on the nature of the research and their potential involvement. I answered their questions truthfully and honestly.

In one of the accounts presented in this thesis I found the process of consent especially challenging and in these instances I deviated from the process of formal consent. I wish to explain here my reasons for departing from the format. This pertained to the use of the word 'schizophrenia' and the potential of presenting the consent form. This form specifically included the schizophrenia dimension in its title. Prior to commencing the fieldwork, neither I nor any of those who reviewed the application considered the ramifications of completing the consent. It was only in the exercise of considering the practicalities of recruitment that the problem surfaced. By implication, the signing of this form placed the service user in a position of acknowledging or accepting her or his diagnosis of schizophrenia, an acceptance not universally accepted by many given the diagnosis. Greg was one person in this category. As a part of my work with Greg, the clinical psychologist with whom I worked closely, in developing the care approach, maintained that our approach to him should explicitly avoid the use of the diagnostic label 'schizophrenia' and even the sobriquet 'psychosis'. My enforcing the completion of the form I believed would effectively 'sign up' Greg to the diagnosis, a predicament that I felt in the course of his care Greg should not be placed. Greg was fully aware of my role in the clinical environment and my research. I asked Greg for his permission to include his story in my work; he provided verbal consent for its use.

Informational privacy and confidentiality are also required in the assurance of autonomy at both the data collection and data analysis stages. In this report, I have tried to ensure that all other information cited in the report, would not identify participants, or link the participant with or to the particular health service involved in the study. I applied pseudonyms to all of the characters and the sites in an attempt to protect the identity of the participants. When discussing the project with members of the community mental health team, given the nature of the team's membership, where some disciplines had only one representative, it would be clear that it would be impossible to ensure confidentiality should other members of the team read the research. I emphasised this during the information sessions I conducted with them. Team members still provided consent, even when I identified this aspect to them. I stored data in accordance with the Data Protection Act (amended 2003), with all computerised data retained on a password protected system.

Justice
The principle of justice ‘demands that the ethnographer should aspire to even-handed treatment of all participants’ (Murphy and Dingwall 2007:346). The central application of
justice in this ethnography applied to the manner in which I applied the principle to the provision of care. This placed the service users' requirements as paramount in all of the aspects of the study, to ensure no burden was imposed unduly on any participant. At times, this meant aspects of the study being placed to the background, as crises arose requiring immediate attention.

Synopsis
This chapter detailed the methods by which I obtained the data for this ethnography. The study adopted autoethnographic principles with data collection using participant observation in a community mental health team, as both full observer and full participant, over a calendar year. During the study, I acted as key nurse to fifteen people, eight of whom received a diagnosis of 'schizophrenia'. The data came from my field notes, interviews and service documents, which I analysed using 'grounded theorising' (Hammersley & Atkinson 2007). Contained in the following chapter is a description of the field, which explains the day to day functioning of the community mental health team under the prevailing service and legislative provisions.
Chapter 4: An Ethnographic Description of the Field

Introduction
The chapter provides a description of the fieldwork setting. In particular, the chapter focuses on the psychiatric nurses within the team (especially the three Clinical Nurse Specialists) and their role. The chapter begins with an outline of the mental health policy and organisational structures, which framed the setting for the ethnography. It also details the location, history, and demographics of the Glenvilly sector, which comprised two large towns, Glenvilly and Castlequarry and their hinterlands. The chapter then looks at the structure and organisation of the mental health services in the sector. It goes on to describe the day-to-day functioning of the team and the work life of the psychiatric nurses and the clinical nurse specialists, the relationships they have with other staff in a community mental health team and those with people given a medical diagnosis of schizophrenia. I have based the description around Mitchell’s (1991) basic questions for ‘...gathering rich ethnographic data’ (Charmaz & Mitchell 2007:162-163) (Appendix 12). The chapter is based on the observations made over the course of the year; however, the bulk of the observations surrounding the structure and organisation of the team come from the initial three months of the fieldwork where I was ‘full’ observer rather than ‘participant’ (Gold 1958). All of the names used in the study are pseudonyms.

Origins of the framework for providing care
At the time of this study, the Health Service Executive (HSE) managed the provision of health and social services in communities and hospitals across Ireland. As a publically funded body, it had an annual budget of over €15 billion and was Ireland’s largest employer with a staff of 140,000. Subdivided into four administrative areas, at the time of the study it had 32 Local Health Offices.

In 2001 the National Health Strategy ‘Quality and Fairness: A Health System for You’ (Department of Health and Children 2001:70) outlined a plan for the future of health services in Ireland for the next ten years. In relation to mental health, in Objective 4 it identified that a “...national policy framework for the further modernisation of the mental health services, updating ‘Planning for the Future’” (Department of Health 1984) was essential. In fulfilment of this objective the then Department of Health and Children commissioned an ‘Expert Group on Mental Health’ to create a blueprint for mental health service development over the next 7-10 years. Its subsequent report was entitled ‘A Vision for Change: Report of the Expert Group on Mental Health Policy’ (Government of Ireland 2006c).

When published, ‘A Vision for Change’ (Government of Ireland 2006c) recommended the creation of mental health catchment areas of between 200,000 and 400,000 people, to be run locally by a Mental Health Catchment Area Management Team, under the national control of a National Mental Health Service Directorate within the Health Service Executive. Prior to the publication of ‘A Vision for Change’, Community Mental Health Teams (CMHT), each serving a geographical sector with a population of approximately 25,000 people, provided mental health care provision at a local level. ‘A Vision for Change’ proposed to increase these numbers to a minimum of 50,000 people per CMHT.

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‘A Vision for Change’ proposed that CMHT’s adopt a ‘holistic approach’ to mental health care, employing ‘specialist expertise’ (Government of Ireland 2006b:8). The policy envisaged that CMHT’s would use an integrated approach to address ‘the biological, psychological and social factors that contribute to mental health problems’ (Government of Ireland 2006b:8). It also expected the CMHTs to reduce greatly the numbers of people requiring inpatient services in psychiatric hospitals.

Glenvilly and Castlequarry
To prepare a realist/reflexive autoethnographic account of care when working with people with a medical diagnosis of schizophrenia, I conducted my fieldwork as a member of the Community Mental Health Team in Glenvilly (pseudonym), between 6th January 2009 and 18th December 2009. The area around Glenvilly has a long history of habitation dating back 5000 years. Although once a farming community, the advent of industrialisation in the 1860s saw the Glenvilly population expand, largely due to woollen manufacture based at the Glenvilly Woollen Mill, which at its peak employed 600. The area also thrived with the presence of both flax and flour milling.

Today the area is suburban, with an economy based more on industry than its agrarian roots. Originally starting as ‘Main Street’ towns, the expansion of both Glenvilly and Castlequarry were characterised by the development of suburban housing estates in the 1980s and 1990s, with house prices in the area considerably higher than other places outside of the main city. At the most recent census in 2006, the Glenvilly area had a population of almost 32,000 divided principally between two towns, Glenvilly and Castlequarry. With good road and rail links, the sector sits on the commuter belt of the city with the towns serving as feeders to the city’s commercial centre. The Glenvilly sector was one of the first areas to benefit from Ireland’s economic boom in the early 1990s and its population rapidly increased from approximately 9,500 in 1991 to over 17,000 in the case of Glenvilly and from approximately 13,000 to over 14,500 in Castlequarry.

In 2003, the Glenvilly sector had the highest average per-capita income outside of the capital city, and throughout the economic recession of the 1980’s it had the lowest unemployment rates. Multinational corporations dominated the employment landscape of the area providing high-income jobs, principally in the computer, pharmaceutical and grocery distribution sectors. In the noted economic downturn of 2008-2009, employment within these companies in the area increased when employment in all other areas fell nationally.

The Mental Health Service in Glenvilly
When I conducted this study, Glenvilly was a part of the Rathmullen Mental Health Catchment Area that at the census of 2006 had a population of approximately 200,000. The Glenvilly Community Mental Health Team was one of five teams in the region. With the population of approximately 32,000 in the sector the Mental Health Catchment Area Management Team, comprising the Medical Director, Director of Nursing and Hospital Administrator, ultimately proposed to amalgamate the Glenvilly team with its neighbouring sector, however they did not implement this plan by the completion of the fieldwork.
The Community Mental Health Team
The Glenvilly CMHT occupied the west wing of the town’s health centre, which was located on the town’s then western boundary. Spread over two floors, the downstairs housed the team’s day hospital, with the homecare and clinical nurse specialist teams based on the upper floor alongside the offices for the consultant psychiatrist, registrars, psychologist, social worker and occupational therapist.

Also based in the centre was the primary health care team, the community dental service and the community welfare officer. A smoking cessation officer and a community addiction counsellor also worked from the centre on a sessional basis. In addition, the centre served as the base for the local area General Practitioner (GP) out-of-hours service. Largely in line with the ‘A Vision for Change’ plan to provide 35 acute in-patient beds for 300,000 people, the Glenvilly team had access to inpatient beds within a 29-bedded acute psychiatric admission unit, Meadowfield, based in Rathmullen General Hospital. The hospital was approximately 20 miles away from both towns. The CMHT took great pride at using beds in Meadowfield as infrequently as possible. During my year working with the team, the number of people admitted to the unit never exceeded two on any given day; half of the team’s allotted quota. Sometimes, they used none.

Organisation of care: the multi-disciplinary team
The organisation of services in the Glenvilly sector closely mirrored the blueprint outlined in the ‘Vision for Change’ (Government of Ireland 2006c) document. The Glenvilly sector was one of four managed centrally from Rathmullen Hospital. Administratively a triumvirate management team ran the Mental Health Catchment Area, comprising a medical director, director of nursing and hospital administrator, who made decisions on service resource allocation.

Multi-disciplinary care was central to the plan in ‘A Vision for Change’ (Government of Ireland 2006c). The Glenvilly CMHT matched the ‘Vision’ blueprint in most details. It comprised a consultant psychiatrist, two psychiatric registrars, eleven psychiatric nurses (including 3 clinical nurse specialists), a clinical psychologist, an occupational therapist, a social worker, and a secretary who provided administration support to the team. The Mental Health Act 2001 provided for consultant psychiatrist led mental health care, empowering them to detain and treat people on the grounds of mental illness. There was an on-going dispute as to the working hours of consultants within the HSE (Government of Ireland 2007) at the time of the research. The HSE contended that the contract should provide for 39 hours activity per week, inclusive of what it described as six hours of ‘un-schedulable’ activities32. Hospital consultants maintained that they were expected to provide 11 3-hour sessions, divided as 7 or 8 clinical sessions with 3-4 flexible sessions dedicated to ‘training, research and management activities’ with ‘provisions for on-call availability’ (Government of Ireland 2007:8). The medical services in

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32 The HSE in its version of the contract maintained the consultant contract agreed 39 hours per week. This included six hours defined as ‘unschedulable activities’. The consultants contended that the HSE contracted for a 33-hour week. There is no definition for what constitutes ‘unschedulable activity’. The Comptroller and Auditor General’s report notes that: ‘It is disappointing that this matter has not been resolved in the ten years since the contract was signed in 1997’ (Government of Ireland (2007) The Consultant’s Contract: Special Report of The Comptroller and Auditor General. Health Service Executive, Dublin.)
Glenvilly met these contractual hours, with eight clinical sessions and three dedicated to administration.

In 2005, the team prepared its mission statement then described as ‘a work in progress’. It focused on acute and home-based care provision. It identified the team’s aim as providing:

“...a comprehensive, multidisciplinary and patient centred care to acutely ill patients in their homes and communities. This approach aims to respect, empower and enable service users and their families to participate in decisions regarding their care and treatment. Our practice will be based on the fundamental principles of the National Health Strategy, namely Equity, Accountability, Quality and People-Centeredness.”

As of 2005, a stated objective for the team was that it would create policies and procedures for the Day Hospital and continuing care parts of the team; that aspiration remained unfilled at the time of the research. According to the Assistant Director of Nursing for the area, the team did not revisit the statement after I left.

During the observation phase of the fieldwork, I drafted a map of the team’s paradigm of care (Fig. 11) and organisational structure (Fig. 12). The consultant subsequently adopted both documents as templates, to demonstrate the team’s structure, utilisation of services and placement within the overall service framework. The Glenvilly Community Mental Health Team placed the service user and their family at the centre care of a paradigm of care, alongside itself and the General Practitioner (GP) who acted as gatekeeper to the services. The team provided care in a number of environments, including homecare, outpatient, day hospital, day centre and inpatient care. It also offered long-term support to service users through Clinical Nurse Specialists (CNS), high, medium and low support hostel accommodation and access to rehabilitation services based at Rathmullen General Hospital. In addition to these resources, the team provided referrals to services both internal and external to the HSE, such as community welfare officers, the National Learning Network[^1] EVE Holdings[^2], local counselling services, youth outreach organisations, housing support agencies and voluntary organisations who supported people with mental health difficulties.

The CMHT used the Glenvilly Health Centre as its base and operated from Monday to Friday, 9am-5pm. The team did not see new referrals outside of these hours and it directed these to the Accident and Emergency Department of Rathmullen General Hospital, where a psychiatric medical registrar or consultant on-call conducted a review. Where necessary, they admitted

[^1]: The National Learning Network (NLN) is an Irish non-Government training organisation. It has centres throughout Ireland offering 5,000 places for people who find it difficult to gain employment or need to develop skills to move forward in life. Offering more than 40 different vocational programmes, the programmes have recognised certification at both national and international level and are designed to prepare candidates for jobs or to progress into further education. The NLN also provides continuous professional development courses and a disability support service.

[^2]: EVE’s primary mission is to provide community-based recovery-orientated services for adults who experience mental health problems. Using vocational, rehabilitation and clubhouse approaches the organisation operates across eastern HSE regions. They aim to develop wellness through hope-inspiring recovery-oriented services.
people to the hospital's psychiatric admission unit or referred them to the CMHT for review. The Glenvilly team's consultant psychiatrist or registrar reviewed admissions the following day. Where people attending the day hospital, homecare or clinical nurse specialist teams required additional support over the weekend, two psychiatric nurses on the team provided care between 9am-5pm, where necessary. All nurses on the team did these 'on-call' duties on a rota basis. The CMHT decided which people needed support at the team meeting each Thursday morning. This support consisted of either a home visit or phone call, as decided upon at the team meeting. Team members informed people that if they required additional support outside of these hours in an emergency, they should contact the admission unit at Rathmullen.

Case Management/'Key nursing'
Under the Mental Health Commission's Quality Framework (2007b:20), each service user should have a designated member of the multi-disciplinary team or 'key-worker' responsible for coordinating "... an individual care and treatment plan that describes the levels of support and treatment required in line with his/her needs...". The team operated a system of case management using the 'key-worker' system. Nursing staff predominately filled the 'keyworker roles' within the team. The occupational therapist, social worker and psychologist also acted as 'key-workers' for a small number of service users. Medical staff did not act as keyworkers. Where nurses fulfilled the 'keyworker role', they received the description 'key nurse'. Every person attending the service had a designated nurse, irrespective of keyworker allocation.

In addition to the medical and nursing staff, as stated the team consisted of three other members; an occupational therapist, social worker and clinical psychologist. Each of these team members provided specialist expertise. The clinical psychologist worked a 39-hour week, consisting of 20, 1-hour clinical slots per week where they consulted with people, with their remaining time spent on educational, administration, supervision and travel time. The clinical psychologist specialised in cognitive behavioural interventions in psychosis and had completed a programme at the Institute of Psychiatry (IoP) in London during the time of the fieldwork. The team's social worker specialised in systemic family therapy and her workload largely consisted of service users with child involvement. The occupational therapist completed a specialist programme in Dialectical Behaviour Therapy and ran the educational programme attached to this weekly. Each of these team members estimated that approximately 20 to 30% of people allocated to their care received a diagnosis of schizophrenia. The fourth additional team member was the clinic's receptionist/secretarial support.

Documentation and assessment
The community mental health team maintained its own service user's notes on site in the community centre. These files did not leave the building. If a person required care in another part of the Rathmullen service, that area kept a separate service user file. For many of the service users diagnosed with schizophrenia the files contained information documenting more than ten years of their life.

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35 Dialectical Behaviour Therapy is an approach to working with people diagnosed with Borderline Personality Disorder devised by Dr Marsha Linehan using cognitive behavioural techniques and mindfulness to regulate emotions.
The file contained five sections housed in a segmented expandable manila folder, with separate sections for medical and nursing notes. Psychology, occupational therapy and social work notes formed another section. Other sections included the treatment care plan and structured assessment tools, a section for laboratory reports and another for referral forms. The files became so large, bloated principally by nursing notes, drug prescribing and record sheets and haematological tests that the holders in the filing cabinets buckled and separated with the weight of the files. The folders proved inadequate in many cases, the plastic retainers snapped and pages became torn and loose with repeated use.

The inside cover of notes contained the demographic information relating to the person. Then followed an individual summary that tracked the number of presentations to the service, categorised according to homecare, day hospital or inpatient admission. Placed prominently at the start of the file was a risk profile detailing episodes where the person may have presented as a danger to self or others. The medical section contained details of the relevant medical, family, psychiatric history, personality function and existing social circumstances, also noted were any major life events identified as significant.

The team took great pride in its assessment structures, highlighting these aspects in its Health Service Executive review. At its foundation, the team agreed to integrate both medical and nursing care plans into a single multidisciplinary service care plan. Within the team, assessment was the primary function of nursing. Case notes contained a structured assessment algorithm (Gamble & Brennan 2006) utilising a number of structured assessment tools. The algorithm devised included a global assessment, FACE mental health toolset licensed from FACE Recording & Measurement Systems (2000), and more detailed clarifying assessments36.

The FACE assessment uses numeric values to rate a range of psychosocial criteria over the previous 72 hours. These criteria assessed behaviour, cognitive functioning, mental health, activities of daily living, interpersonal relationships, family and informal carer support, social circumstances, physical well-being, the person's response to care and an assessment of overall functioning rated over the previous three months. Nurses conducted the FACE assessment within 72 hours of referral. A brief risk assessment augmented the use of FACE.

In addition to FACE, the team used a number of clarifying assessments, which under the algorithm were tailored to individual clients. These included the Montgomery-Asberg Depression Rating Scale (MADRS) (Montgomery & Asberg 1979), the Clinician-Administered Rating Scale for Mania (CARS-M) (Altman et al. 1994), the Hamilton Anxiety Rating Scale (Hamilton 1960) and the TWEAK screening test for alcohol misuse (Chan et al. 1993). Where the team suspected a diagnosis in the schizophrenia spectrum, occasionally they used two additional assessments the PANSS (Kay et al. 1987) and UKU (Lingjaerde et al. 1987). Kay et al. (1987:261) describe the Positive and Negative Syndrome Scale (PANSS) for Schizophrenia as providing a ‘balanced representation of positive and negative symptoms and gauges their

36 Gamble and Brennan (2006) outline that an assessment algorithm should have a progression in the assessment process leading from a broad-based ‘global’ assessment tool for initial identification of problems which are subsequently explored in more detail using ‘clarifying’ assessments. The Positive and Negative Syndrome Scale (PANSS) (Kay et al. 1987) used to identify symptoms in schizophrenia is an example of a clarifying assessment.
relationship to one another and to global psychopathology' however its original use was in evaluating the effectiveness of medication. Although not entirely reserved for people diagnosed with schizophrenia, the team used the UKU Side-Effect Rating Scale (Lingjærde et al. 1987) to assess the side effects of psychiatric medications. This is a clinician-rated scale based around a semi-structured interview that assesses the effects of medication over the previous 3 days. In addition to the evidence-based structured assessment tools, that team had devised its own tool to collect a collateral history from the person’s family. This was a semi-structured interview completed by nurses with a family member designated by the person.

**The distribution and stratification of psychiatric nurses**

Nurses were the most numerous group among the team, totalling eleven. They comprised an Assistant Director of Nursing (ADoN), and two Clinical Nurse Managers, with responsibility for the day hospital and homecare team. The team employed three clinical nurse specialists who had responsibility for long-term service users’ needs. The Clinical Nurse Specialist grade equated to that of the clinical nurse manager. The five staff nurses worked between the day hospital (one) and the homecare team (four). As a group, all of the nurses were white Irish. The gender balance was nine women and two men. All of the nurses trained in Ireland. Their ages ranged from 24 to 60. Educationally, two attained Master’s in Management degrees, four acquired postgraduate diplomas and the remaining five held bachelor’s degrees.

The Assistant Director of Nursing had overall authority for nurses working on the team and reported directly to the director of nursing at Rathmullen. The clinical nurse specialists operated with a degree of autonomy and had direct reporting arrangements to the Assistant Director of Nursing. Both clinical nurse managers reported to the assistant director of nursing as their direct line manager, whilst the staff nurses reported to the clinical nurse manager in their area.

During the time I conducted the research, the team had its full complement of staff. Staff worked in the area based on a two-year commitment to the team. Five of the eleven nursing staff present at the start of the fieldwork, were on their third 2-yearly cycle, having joined the team from its outset. The three clinical nurse specialists were three of those five. Four others were in their third year and the remainder in their first. In a form of succession planning, those working in the clinical nurse specialist roles and clinical nurse manager roles, all had previous experience working as staff nurses in the area, effectively promoted from within.

**The settings for actions: places and activities over time**

The delivery of care happened across a number of settings in the community and the health centre. The primary settings for activity were the day hospital, homecare and clinical nurse specialist care.

**Day Hospital**

Staffed by a Clinical Nurse Manager 2, a psychiatric nurse and occasionally a student nurse, the day hospital had 12 places for service users on any given day. Service users attended the service between one and five days per week depending on their level of need. The day hospital opened to service users at 10 AM, with the service ceasing at 3:30 PM. In her description of the day hospital, Aisling, a young woman given a diagnosis of schizophrenia, described it as a "safe
haven". The principal activities of the day hospital were assessment, monitoring, medication management, activation with exercise classes and art therapy, and education with personal development.

Homecare
Established in 2004, the team took great pride in the work of its homecare initiative. Operating from the first floor of the health centre, the team comprised a clinical nurse manager 2 and 4 staff nurses. The team had a dedicated psychiatric registrar. Developed using Health Services National Partnership Fund \(^{37}\) money and proposed to operate in conjunction with its neighbouring sector, the bulk of the team's work concentrated on people from the Glenvilly area. Over the course of the year, the homecare team received between 70 and 80 referrals per year of people from Glenvilly. It estimated 21% of these service users had a diagnosis of schizophrenia. The mean length of time people spent on homecare was 31 days and on average, a nurse on the team attended 13 people over the course of a month. In their philosophy team espoused principles of person centred care; supporting the person's autonomy, and encouraging active involvement and accepting responsibility for decisions around their own care. It also emphasised support for families and carers where appropriate. Admission rates from the team to inpatient services from the Glenvilly area were lower than the figure achieved by the well-publicised Cavan Monaghan home care team.

Clinical nurse specialist care
When the CMHT considered that a person would require a long-term relationship with the service, they transferred the person to the care of a clinical nurse specialist (CNS). Of approximately 150 service users in long-term care on the team's books, the consultant psychiatrist identified one hundred and four as having a medical diagnosis 'in the schizophrenia spectrum'. The 150 service users were divided roughly equally among three clinical nurse specialists, in addition to a number of 'inactive cases'\(^{38}\).

The clinical nurse specialists had particular areas of expertise mostly acquired at post-graduate level. This included specialism in enduring mental health, bereavement and clinical assessment. People allocated to clinical nurse specialist care had a regular medical review at 'outpatients', usually on a three-monthly interval or possibly sooner if the clinical nurse specialist had concerns that the person was not coping and needed review.

Outpatient clinics
Held every Wednesday, the clinical nurse specialists ran the outpatient clinic. Starting at 9.30AM and running to 2.00PM, people attended for medical review by either the consultant or one of the two registrars, a depot clinic and a phlebotomy clinic. The psychiatrist or registrar did not review everybody attending for depot injection or phlebotomy. Each registrar's clinic was

\(^{37}\) The Health Services National Partnership Forum (HSNPF) was established in a national agreement on social partnership in 2000. The function of the HSNPF was to champion partnership between the health services management and trade unions.

\(^{38}\) Clinical nurse specialists kept a number of people on their caseload with whom they maintained occasional contact. Although officially discharged from the service, the team considered they might be vulnerable and at some point might possibly need support. The CNS's might try to see such people at a three to six month interval in a casual way.
organised into 10-minute sessions, resulting in 21 appointments per registrar. The consultant varied the duration of his appointments depending on the person's acuity and usually saw 8 to 10 people over the course of the clinic. Depot clinics had on average 15-20 attendees, whilst the phlebotomy clinic had 10-12 attendees. Each clinical nurse specialist kept contact details for the service users they worked with in their mobile phone. Contact numbers were also available in the person's case notes. When people were late for outpatient appointments the clinical nurse specialist telephoned the person reminding he or she about the appointment. This call served a fourfold purpose. Those who had simply forgotten received a reminder from the nurse, who slotted the person down on the list for later on if they were able to attend. It reminded people unable to attend of the necessity to notify staff and provided an opportunity for staff to remind them about resource wastage. The telephone call allowed the nurse to assess if a person was coping and if they needed assistance. It also provided a contact point, which the nurse would document in the service user notes, verifying staff contact with a person.

The outpatient clinic concluded with a CNS team discussion of the clients who attended or failed to attend the clinic. During the meeting, the clinical nurse specialists with the consultant identified people who they would visit for follow-up; non-attenders received a letter and a new appointment. In addition, they discussed issues specific to clinical nurse specialist care that did not require the full team's attention at the meeting the following morning.

Team Activities

The team working week was organised around a number of structured activities (see figure 13). Central to team activity was the meeting room on the first floor of the health centre, where many of these took place. These activities had a high level of nursing involvement. Beginning with Monday the homecare team met first thing in the morning. All of the nurses on the homecare team attended the meeting, in conjunction with the nurses who provided on-call cover over the weekend. The consultant psychiatrist and psychiatric registrar also attended this meeting to review service users' progress over the weekend. After a short recess, a care plan meeting followed the homecare team meeting. This usually ran for between one and two hours and established treatment plans for new service users. Membership at this meeting usually comprised the consultant psychiatrist, clinical psychologist, registrar and 'key nurse' of each service user. The development of the treatment care plan was multidisciplinary in nature and considered a number of domains. Where the team identified an intervention, it allocated a member of the team to complete the task. Service users did not attend these meetings, but, following the drafting of the plan, the 'key nurse' was expected to discuss the care plan with the service user. In this instance, although the treatment plan provided space for the service user to sign, this happened only on rare occasions.

On Tuesday morning the meeting room held the Dialectical Behaviour Therapy program group session; whilst in the day-hospital, the first Tuesday of each month staff ran a Clozaril Clinic. Each Wednesday, the meeting room became the centre for outpatient clinics, which were followed immediately after by the clinical nurse specialist team meeting. On Thursday morning, the meeting room became the venue for the weekly team meeting where the bulk of communication happened, with staff present from the homecare, CNS and day hospital teams. The consultant psychiatrist and psychiatric registrars dedicated each Tuesday to reviewing new
referrals who attended in person. Following this review, service users were referred on to nursing staff who completed structured assessments.

The team dedicated Friday afternoon to emergency review; these happened either through their 'key nurse' scheduling an appointment or occasionally on a drop-in basis. On Friday afternoons, the day hospital team reviewed the progress of attendees. Where necessary, the team arranged family meetings and feedback sessions with service users, for either Tuesday or Thursday afternoon. In the remainder of the working week nurses engaged in face-to-face interaction with service users and their families.

![Figure 13 Nursing Team Scheduled Activities](image)

### The CMHT Service Remit

Burns & Drake (2011) consider that the treatment of psychotic states and the diagnosis of schizophrenia have been central to the development of psychiatric care. They consider the funding for mental health services within societies most commonly determines the approach adopted. For the majority of people given the diagnosis of schizophrenia, service provision is predominately state funded in origin. Care delivery occurs across a variety of places, and usually comprises a mixture of inpatient and outpatient treatment, with a degree of family involvement. Burns & Drake (2011) identify that the predominant model of care in the diagnosis of schizophrenia is Assertive Community Treatment (ACT)\(^{39}\), usually delivered as either

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\(^{39}\) The principles of Assertive Community Treatment derive from an original programme entitled 'Training in Community Living' work developed by Stein and Test (1980) at The Mendota Mental Health Institute, Madison, Wisconsin. Also known as the 'Program of Assertive Community Treatment (PACT)' (see also Marx, Allness & Knoedler) the approach is sometimes referred to as the "Madison Model". The service in the UK and Ireland more commonly use the term Assertive Outreach (AO). In assertive outreach, the healthcare worker takes responsibility for the complete package of care, a client receives working either in a dedicated assertive outreach multidisciplinary team or may be a specialist working in a more generic community mental health team. As a collaborative approach, it is most frequently used when working with people who present with complex needs, are considered as high risk, who pose difficulties with
brokerage case management or clinician case management. ACT represents the most widely researched approach to mental health care delivery (Burns & Drake 2011). Initial research in the United States identified that the approach led to a reduction in hospitalisation and greater tenure in the community and better social adjustment. However, more recent research outside of the United States, has failed to replicate the initial positive results of the Madison Model (Stein & Test 1980) and researchers now concede that standard multidisciplinary care is equally effective. In some countries, notably Germany and Sweden there are attempts to separate long-term care in psychosis from medically dominated hospitals and transfer its care into the domain of social workers.

Although the community mental health team operated using many of the principles of assertive community treatment when asked, the consultant psychiatrist considered that the team did not formally subscribe to a particular model of care, but it did fulfil most of the criteria identified by Phillips et al (2001):

i. The services were comprehensive and flexible

ii. They provided access to care on a 24-hour basis

iii. They used low staff to service user ratio in homecare

iv. Care targeted individuals with severe mental illness as a priority and provided treatment, support, and rehabilitation services directly using team members.

v. The team set no time limit on people on receiving services.

vi. The team carried out interventions where problems occurred in the community, rather than in hospital and clinical settings.

vii. The team was assertive in the way it engaged with individuals, actively initiating contact with non-engaging service users, following up on treatment and monitoring of progress.

viii. The service operated with care plans individualized to each person.

Where the team differed most from Phillips et al. (2001) assertive outreach principles, was that unlike the assertive community treatment, where team members share responsibility for people, members of the team operated using a ‘case management system’. In addition, nurses working with long-term service users on the clinical nurse specialist team managed higher allocations.

engagement or reject services. The approach looks for ‘flexible and creative ways’ to respond to people to provide a ‘quick and immediate response to needs’ encouraging a long-term commitment to care. Assertive Outreach tries to develop the service users’ capacities to identify and address their own needs at a local level. The objectives of AO are to prevent admissions and reduce dependency on hospital-based care by providing intensive support in the community. The strongest critiques of the AO approach concern the evolution of a team approach, which exerts social control, becomes paternalistic, risk aversive & over-vigilant. Within the team, a strong emphasis develops on medication interventions and compliance. Phillips et al (2001) consider the approach may foster dependency long term.
When it came to decisions as to what access to services people would have and what type of service users, the team would prioritise, staff debated its role in the context of the wider organisation and budget. It considered this role over the course of a team meeting on Week 33 of the fieldwork. The team considered that its primary function was to provide assessment and treatment for people in the local community, who presented with Axis I (serious) psychiatric disorder. Here the Community Mental Health Team would make a decision to accept a person for treatment following psychiatric and psychosocial nursing assessment. Where the assessment did not identify a major psychiatric disorder, the CMHT would direct the person to alternative services such as the youth counselling service where appropriate. Where no such services existed or were not readily available, the multidisciplinary team undertook to communicate this unmet need or gap in services to the relevant HSE personnel.

The team felt that in some circumstances, it might provide assessment for some people who presented with psychological disorders other than those in 'Axis I'. They acknowledged that this might require a more comprehensive assessment, involving other team disciplines (i.e. psychology, social work, occupational therapy). In these instances, the CMHT would only make the decision to accept the person for treatment following this more comprehensive assessment.

**Pathways to care**

The team operated a triage system for referrals, put in place when it was established. The majority of referrals to the CMHT came from General Practitioners (GP’s), with some additional referrals from Rathmullen Hospital. These referrals came principally by fax and occasionally by telephone to one of the nurses on the team who acted as a liaison nurse with the GP. This nurse carried a dedicated mobile phone for liaison purposes. Faxed referrals came on a form devised by the team, indicating the priority of the service user. The GP liaison nurse followed up the referral by telephone with the GP and on discussion with the consultant, arranged appointments for review based upon the level of urgency. In practice, the team saw all referrals within 72 hours. Where the GP deemed that a service user required to be seen as 'very urgent', the team provided an appointment within 24 hours. This usually consisted of an initial assessment by the consultant psychiatrist and medical intervention, with follow-up undertaken by the nurses on the homecare team. Where necessary, the team might offer a place in the day hospital or, in extreme circumstances, admission to Meadowfield, the psychiatric inpatient unit at the Rathmullen General Hospital.

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40 The terminology ‘Axis’ comes from the American Psychiatric Association’s publication ‘The Diagnostic and Statistical Manual’ (American Psychiatric Association 1994). The fourth incarnation of the manual, in clinical use throughout the formulation of this thesis, categorised psychiatric diagnoses into five categories. Interestingly, the Irish Mental Health Services do not use this diagnostic categorisation, preferring to use the more widely adopted International Classification of Diseases (ICD-10) (World Health Organization 1992). The ‘DSM-IV Axis I’ category includes major mental disorders such as Depression, Anxiety, Bipolar Illness, Anorexia Nervosa, Bulimia Nervosa, and Schizophrenia; learning disorders like Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorders and substance misuse. ‘Axis II’ includes personality disorder and intellectual disability, whilst ‘Axis III’ describes disorders related to acute medical conditions and physical causes. ‘Axis IV’ describes psychosocial and environmental factors contributing to the disorder and ‘Axis V’ is a Global Assessment of Functioning.

41 The triage system categorised referrals as either urgent or non-urgent.
Where the GP deemed a service user's priority less urgent, one of the nurses attached to the homecare team conducted the initial assessments. The consultant psychiatrist reviewed the person following this initial assessment, and the team devised a treatment plan at one of its regular Monday meetings dedicated to this purpose. The consultant then referred the person to the psychiatric registrar in conjunction with the nurses from the homecare team for the management of on-going care. Following initial treatment, usually with medication and a more detailed assessment, the person's care plan might be adapted to include referral to the clinical psychologist, psychiatric social worker or occupational therapist.

The Schizophrenia Spectrum
A term not seen as a classification in either the ICD-10 or DSM-IV, in Glenvilly the consultant psychiatrist used a diagnostic term 'in the schizophrenia spectrum'. He used the term without formally diagnosing the person with 'schizophrenia' and he rarely used the word 'schizophrenia' without 'spectrum' attached. In my experience most other consultants I worked with, would make the diagnosis 'schizophrenia' where he diagnosed 'schizophrenia spectrum'. During the first week of my fieldwork, I discussed with the consultant psychiatrist the number of people attending services in the sector. He identified that there were on average 220 people in active care in the service, spread between in-patient, day hospital, homecare and CNS/out-patient care. This fluctuated with seasonal variation, during the summer months (May-August) numbers dropped by approximately twenty per cent. Of the 220 people, the consultant identified 150, whom he regarded as needing support on an on-going basis (>6 months), and one hundred and four as having a medical diagnosis 'in the schizophrenia spectrum'.

Meetings
Held each Thursday morning, all team members were expected to attend the 2-3 hour team meeting. It was made a condition of my joining the team that I would attend, so as to be familiar with the team's working, decision making and have some understanding of individual service users, should I be required to assist in his or her care in the future. I participated in over thirty team meetings in discussions on care. Conducted in the team's large meeting room in the health centre, staff congregated around a large central table. 14-16 of the CMHT members regularly attended the meetings, depending on leave and on-call arrangements. This was the forum where the team made decisions and debated the approaches it would take. The service user's note contained a single assessment section along with a single multidisciplinary care plan. The only exception to this was the clinical psychologist, who maintained separate files on her caseload. She stored these in a locked filing cabinet separate from other files. Routinely, other staff did not access these files, doing so only with the psychologist's permission. Four-drawer metal filing cabinets, seven for current service users and seven for those no longer active in the service occupied two walls of the room. These service user notes were readily accessible when an unanticipated discussion of a service user occurred.

42 Tsuang et al (2011) credit Seymour Kety with the introduction of the term to psychiatry in 1968, although the existence of a dimensional concept to the diagnosis was not new, with Angst (2007) crediting Kretschmer in 1921 as first to propose a dimensional concept for schizophrenia, followed by Bleuler in 1922.
Prior to team meetings, team members vied for a comfortable seat in one of the eight high backed armchairs in the room. Even though the meeting would not start until 9.30am, people would place markers on the chairs up to an hour earlier, handbags or diaries marking the territory as occupied. This practice reflected the lengthy nature of the meeting, with durations ranging from 1.5 to 3 hours. One of these blue armchairs, to left of centre at the top of the table, was always left unoccupied prior to starting, reserved for the team’s consultant psychiatrist who always chaired the meeting. On one occasion a regular visitor to the team, waiting on the consultant to arrive, ‘jokingly’ questioned whether she should occupy ‘...the king’s throne’. The chair remained vacant until the consultant arrived.

Over the course of the meeting, the team would review upwards of forty service users, with entries made in each service user’s notes, predominately by the team’s psychiatric registrars. In a scene reminiscent of the ‘old-style asylum’, the nurses responsible for the day hospital and homecare team arrived to meetings with ledgers, pre-filled with the names of those ‘on their books’. They left two or three line spaces under each service user to record potential actions or outcomes resulting from the discussions. To improve the efficiency of the meeting, the nurses placed the service user’s notes for review on the table, organised according to the part of the service and corresponding to the sequence on the list in the ledgers.

The meeting followed a sequence, with discussion on:

i. Service users attending the day hospital (approx. 10-12/week usually with the most severe mental health problems)

ii. Clients on homecare (approx. 15-20/week)

iii. Matters arising from the out-patient clinic (approx. 2-5/week)

iv. New out-patient referrals to the consultant (approx. 2-5/week),

v. Reports from the clinical nurse specialist team from clients on their books (approx. 3-9/week)

vi. Service users in the acute admission unit at Rathmullen General Hospital (0-2/week)

Within the meeting, each of the team members had their particular service users they championed, largely driven by their own particular bonds with individuals. In these meetings, as an observer, I could see emotional involvement with particular service users as each discipline tried to represent the service user’s view, however these perspectives largely reflected their discipline’s own individual perspective and ethos.

Crucially, the team meeting did not just discuss individual cases. The team meeting allowed for reasonable latitude in discussions over approaches, with attempts to deliver ‘collaborative’ decision making on strategy and care. There was a willingness to confront the dilemmas of care and complexity of cases. From the resource perspective at grass roots, during the meeting, staff received briefings of possible developments and discussions in the service.

For the most part, the team made decisions by consensus, but, when they failed to reach agreement, the ultimate decision-making power rested with the consultant. An outsider might view these meetings from two very differing perspectives, that of the professional and that of the service user. The meeting had an inherent power differential. This forum drew together a wealth of experience from diverse professional backgrounds to consider the complexities and
dilemmas that any individual service user might pose. Yet, in this forum, some of those present had no direct connection with the person and yet contributed to decision-making. Moreover, the review process was without the voice or presence of the person. In these situations the consultant relied upon the accounts of the ‘keyworker’ most often as being most representative of the person’s opinion.

Schizophrenia: ‘Treatment as Usual’ (TAU)

Fisher (1994) identifies establishing self-help groups and service user-led services are possible ways to maximise service users’ involvement in their care and treatment. A key to its future evolution is its capacity to embrace other perspectives on mental health problems. Philosophically a strongly ‘medicalised’ identity underpinned the team. During my time with the team, perhaps the biggest challenge that I saw was an absence of a service user perspective in decision making/planning and the ability to incorporate the recovery ethos in day-to-day care.

The consultant used the expression ‘treatment as usual’ (TAU) on a regular basis. This described the team’s approach to care for people presenting with features of the more common ICD-10 diagnostic categories. In the case of people diagnosed ‘in the schizophrenia spectrum’, this consisted of pharmacological intervention for the person, and explanation of the treatment plan, providing knowledge about the diagnosis and treatment and an offer of a place on the family psycho-education programme. During the initial diagnosis phase, the management of the person depended upon the severity of the presentation. Where a person presented a risk to him/herself or others, treatment usually commenced in the in-patient unit. This could happen in either a voluntary or a non-voluntary capacity. When the psychiatrist considered this risk passed, he transferred the person to either homecare or the day hospital for follow up. Where the risk of self-harm or danger to others did not prevail, treatment began in these environments.

Pharmacological intervention

Within the team, prescribing practices usually concentrated upon oral antipsychotic medication. Principal among these antipsychotics were risperidone, olanzapine, quetiapine and clozapine. During the first week of my fieldwork, 34 people (approximately 22% of service users) received a depot injection of antipsychotic medication. The principal medications prescribed in this category were flupentixol, haloperidol and risperidone. In most instances, the team’s psychiatrist commenced these medications at low-dose and titrated up to the manufacturers’ recommended dosages.

Psycho-education

In the early stages of the diagnosis, a specific care plan objective identified for the family was to provide knowledge about the diagnosis. The primary resource the team used to provide information was a book called ‘Discover the Road Ahead: Support and Guidance for Everyone Affected by Schizophrenia’ (Elgie et al. 2004). Taken from a large stockpile in the Assistant Director of Nursing’s office, there was an expectation that nurses on the homecare team would provide a copy of the book to the family to keep. However, in most instances staff did not provide the book until after families attended the psycho-education programme, which
occurred at times six months to a year after the initial diagnosis. The failure to distribute the book possibly related to the reluctance to introduce the term 'schizophrenia'.

The team provided a formal structured family psycho-education programme consisting of six sessions to families who wished to attend. Run by the team once or twice per year, the team sent invitations to relatives in the service where they made a diagnosis of schizophrenia; they sought consent from the service user prior to making the invitation. Up to two relatives from the family could attend in each programme. The team also extended invitations to relatives in other sectors in the Rathmullen region. The team devised its own content and the sessions were clinician led, however, the content of the programme largely corresponded to that run by a voluntary organisation that supports those with the diagnosis of schizophrenia nationally and consisted of six sessions.

In the past, the team sought to run the programme at a neutral venue such as a local hotel. With budgetary constraints becoming a priority, during the fieldwork the team conducted the programme in the day hospital at night-time. A number of different team members facilitated the programme. I acted as one of the co-facilitators in four of the six sessions. In these sessions, although a formal presentation was prepared, the objective was that family members would discuss their own areas of concern, and flexibility was the order of the day. Calculated to last two hours, most sessions ran over, due to the volume of discussion on the topics; participants never left early. Although the team sent invitations using post and phone contact to 42 service-user families for the psycho-education programme, only eight of those families accepted the invitation.

Cognitive Behavioural Therapy in psychosis (CBTp)
As mentioned earlier, the team’s clinical psychologist had some experience in working with cognitive behavioural interventions for psychosis. The UK’s NICE clinical guideline ‘Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care’ (update) released during the fieldwork (March 2009) includes Cognitive Behaviour Therapy in psychosis as an essential part of treatment. The guideline recommends that services "...offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase or later, including in inpatient settings” (National Institute of Clinical Excellence 2009:368). As an intervention for people diagnosed with schizophrenia, very few people in the Glenvilly service appeared to receive an offer of working in this way. I was aware of only three offers made to people during the fieldwork. Two people accepted the offer and one declined, as she argued that she was not in a space to engage with the process.

Other Programs
Where they made a diagnosis in the 'schizophrenia spectrum', the team had the potential to offer places to service users or their families on two other programmes. The first of these was the Dialectical Behaviour Therapy programme, sometimes offered to service users where the person received a dual diagnosis of borderline personality disorder in conjunction with schizophrenia. The second programme, a children's education group, was available as a pilot program during the fieldwork. Delivered by the team’s social worker and one of the nurses on
the homecare team, the programme worked with children in the 10-16 age groups but was not specific to schizophrenia, looking more widely at coping with a mentally ill parent in the family.

My relationship with the team and team members during fieldwork
Over the course of the fieldwork I gained acceptance as a team member. During the initial stages there was some degree of apprehension that individual staff were the focus of the research and at times people felt suspicious, telling me 'now that's not for going down in the notebook'. For the most part I knew many of the staff who rotated through the environment well, some I trained with, others I trained, and many I worked with as I passed on my own career through services. The medical team were quick to accept my presence, as registrars came seeking advice on how to approach research methodologies, once it became known that I has supervised a number of masters research students. My contacts with college and ability to make introductions to collaborators on research projects also increased my acceptance. During my time there, the area secured national research funding for a collaborative project involving the entire multidisciplinary team, service users and voluntary organisations. It produced a research publication and provided a research project for a fulltime MSc student.

In my day to day relations, I appeared as just another staff member. We shared breaks and meals, jokes and social events. By the time I finished the fieldwork, I was part of the team longer that some of the newly recruited staff.

People central to the ethnographic analysis
The following three chapters contain the findings and analysis of the data from the fieldwork. In presenting the findings, a number of people are central to this ethnography. To protect the identity of those involved, the account uses pseudonyms. Other details pertaining to people, their experiences and their roles remain unchanged. To help the reader navigate his/her way through the analysis, the following section introduces these people and the parts they played in the ethnography. In presenting these introductions, I ask the reader not to regard them as a reductionist interpretation of the people concerned, as this is not the intention. They are used as a literary device, in an attempt to acquaint the reader with a little of the persons' background to give context to scenarios as they unfold. Over the course of the fieldwork, a higher proportion of young adult males presented to the service. However, I noted an increasing number of African, married, female service users with children presenting to the service. However, I noted an increasing number of African, married, female service users with children presenting to the service.

Central people given a medical diagnosis in the 'schizophrenia spectrum'

Andrezej
Andrezej was a young, Polish Roma emigrant diagnosed with paranoid schizophrenia in his homeland. Following three weeks as an in-patient in the Rathmullen acute admission unit, Andrezej's consultant transferred him to the care of the community mental health team. Andrezej heard voices that distressed him. The multi-disciplinary team believed that cannabis misuse exacerbated his problems.
Sarah
Sarah was a 42-year-old woman diagnosed with schizoaffective disorder. She was single and lived with her parents at the family home. At 19, Sarah’s parents admitted her to the local psychiatric hospital. Sarah felt the pressures of starting college led to her original ‘breakdown’. Originally in an established key worker relationship, Sarah agreed to my working with her whilst a member of the team. Sarah experienced strange thoughts frequently, which she had difficulty explaining to herself and coping with.

Greg
Greg was 26 and lived with his brother. Whilst on holiday, Greg experienced a blackout in a bar. Following this event Greg believed there was a conspiracy and he was going to die at a predestined time. Increasingly the presence of strange thoughts became distressing for Greg and his GP referred him to the community mental health team, where he received a diagnosis of paranoid schizophrenia.

Aisling
Aisling was twenty-seven and received a medical diagnosis of schizophrenia when she was twenty-one. For most of her life, Aisling lived in Castlequarry. Considered by staff to be a talented artist, Aisling lived alone in a council apartment. Aisling experienced frequent, distressing voices and strange thoughts that meant that she found it hard to live at home.

Other people given a medical diagnosis in the ‘schizophrenia spectrum’

Brian
Brian was a man who received an ICD-10 diagnosis of paranoid schizophrenia sixteen years previous. Brian drifted in and out of contact with the mental health service over that time.

Philip
Philip was a young man who joined my care in the later part of the fieldwork, following his discharge from a private psychiatric hospital. The consultant psychiatrist at the private hospital made the diagnosis of schizophrenia.

Tomás
Tomás a young man with psychotic experiences, which he believed were attributable to cannabis misuse.

Nurses working with people with a medical diagnosis of schizophrenia

The clinical nurse specialist team

Angela
Member of the clinical nurse specialist team; Angela was Aisling’s key nurse

Regina
A member of the clinical nurse specialist team
Shannon
A member of the clinical nurse specialist team

Susan
A member of the clinical nurse specialist team; provided temporary cover during a period of absence

Other Nurses

Bríd
A nurse with the homecare team

Claire
Clinical nurse manager (CNM2) of the Day Hospital at the outset of the study and CNM2 of the homecare team during the later part

Colm
A staff nurse working in the day hospital

Phyllis
A nurse with the homecare team

Paul
A nurse, working in the Day Hospital and homecare team

Sean
The Assistant Director of Nursing

Other multidisciplinary team members working with people with a medical diagnosis of schizophrenia

Dominic
Consultant psychiatrist and leader of the community mental health team

Alison
The team’s clinical psychologist, Alison had a postgraduate qualification in cognitive behaviour therapy as applied to psychosis. She also specialised in working with people diagnosed with borderline personality disorder using Dialectical Behaviour Therapy.

Frances
The team’s social worker, Frances’ principally managed the care of service users with child involvement. Frances had specialist expertise in family therapy.

Will
The team’s Occupational Therapist
Registrars
During the fieldwork four psychiatric registrars worked on rotation with the team, two at a time for a period of six-months, all were Non-Irish, three male and one female.

**Entering the field: initial observations**
I entered the field in January 2009, spending the first three months observing how the team worked. In the following section, I note how I saw the team function during that time. The commentary is structured around the work of Byrne & Onyett (2010), which although written after the fieldwork finished provides a good framework on which to base an appraisal.

**The quality of teamwork in Glenvilly**
Byrne & Onyett (2010) consider accessibility, comprehensiveness, fostering an evidence-based approach, communication and managing professional cultures among the important measures of team functioning.

**Accessibility**
A key measure of quality is accessibility, that services are accessible where and when required. Situated in the local health centre, across the road from the town’s main shopping centre, the team’s location offered ease of access to consultation, at the heart of the community. Within the centre, the entire team occupied the same corridor in the health centre. There was immediate access to all team members; especially important in crisis and follow up situations. Accessibility in the service was in no small part due to the absence of a private consultative caseload, which increased the consultant’s time spent on site. This ensured a greater degree of accessibility and prompter access to medical decision making.

Repeatedly, research into family needs points to having a contact in a crisis as being important; somebody with whom they can liaise. Every person who entered the service had that contact, the ‘key nurse’. Each service user and family member was aware of who that was. The team’s use of technology, principally the mobile phone increased the degree of accessibility. This was not just staff contacting service users, but also in handovers occurring by phone when staff are ‘technically’ off duty.

**Comprehensiveness**
The team offered a comprehensive approach to care. There was a clear care provision structure, with clearly defined strategies for the management of care. There were structured, co-ordinated and individualised care plans, that had clear goals and interventions based on the assessments conducted and co-ordinated to meet service user and carer needs. In addition, the team linked in to external services who could meet service user needs in the areas of occupation and work, finances and housing.

A key element in comprehensiveness was assessment. Based on an algorithm, the assessment was flexible and modifiable to meet an individual’s need. From the assessments, clear strategies, pathways and interventions were in place for the common diagnoses encountered. In interactions, service users received clear expectations for their engagement in the care process, the interventions and expected outcomes.
Fostering of evidence based approach
There was a high level of knowledge within the team with active involvement in post-graduate education. The team facilitated training placements for medical registrars, psychology students and nurses. Most members of the team had a specific expertise that dovetailed well with their roles such as, specialism in enduring mental health, bereavement, psychotherapy, counselling, intervention in borderline personality disorder and systematic family therapy. This 'value added-ness' came as a part of the recruitment and development strategy of the team, effectively ensuring that there was a 'consultative resource' on most topics available within the team when needed. The team management actively encouraged on-going professional development, with flexibility afforded to staff where possible to engage in educational programmes. The team was also involved in research in developing clinical interventions for families, psychosis and the dialectical approach for the management of personality disorder. As a direct consequence of the team's research involvement, service users benefited directly from consistent management strategies based on up to date evidence designed to provide consistency of approaches.

Communication
As detailed above, the communication mechanisms and structures within the team stood out. In addition to the overall team meeting, each part of the team had ‘sub’-team meetings. An important aspect was the inclusion of ‘ancillary’ care services within the team meeting structure, the team had good links to the addiction services, child and adolescent services, EVE and NLN. The team arranged mechanisms with these services for speedy review whenever required.

Managing professional cultures
In line with the 'Vision for Change' (Government of Ireland 2006c) outline, all of the disciplines considered relevant to contemporary practice were represented. Each professional’s caseload was full and actively managed. There was active management of caseload numbers, with periodic systematic reviews of volume and dependency. The team structures stemmed from its original planning; it had the benefit of beginning as a ‘green field site’ and was able to select the staff of choice to build the team. It put the educational structures in place to build the approaches to care at the outset, before accepting any service users. Thus, it began with a clear vision developed by the consultant and the Assistant Director of Nursing for its function and an understanding of what care they believed they could offer.

I noted there was considerable trust placed in the abilities of individual team members and there were reasonably clear limits in which to work. Each team member was aware of his or her knowledge and responsibilities. They knew when the appropriate time came to access each other’s resources. The resultant respect for each other and closeness it engendered led to a willingness to step in, whenever a hole in staffing materialised.

A key element to the success of the team was the nursing management of staffing at a strategic level. When making a transition, the team provided weeklong overlap periods when replacing key team members. At early stages in their career, the Assistant Director of Nursing identified that he made a clear attempt to develop staff and retain them in the area, using internal
rotation within the team positions. This process effectively maintained 'knowledge' and 'historicity' within the service.

**Conflict**

I did not note major conflict amongst the team members. A key feature, which contributed to the absence of conflict, is the degree of socialisation that happens within the team. The team dined together at lunchtime and prior to commencing duty meet for morning tea. In this informal atmosphere, aside from the social element, there occurred considerable discussion and debate relating to the team, with everybody together and the full mix of disciplines, traditional professional barriers became blurred. This provided a more egalitarian base; everybody was on first name terms, they did not use titles, everybody joined in conversations, barriers were absent. On this footing, team members were more likely to find ways of working together rather than territorially. This was not to say that conflict did not exist, largely when it occurred it was healthy and respected individual's competencies. When tensions grew, I witnessed active attempts behind the scenes, both by the Assistant Director of Nursing and the Consultant, to manage these tensions and resolve conflicts within the team.

**Entering the clinical nurse specialist role**

For most people given a diagnosis in the schizophrenia spectrum, the psychiatrist preferred a treatment protocol of a two-year period of neuroleptic medication, with the person remaining symptom free without medication before proceeding with discharge. The established practice within the team was that if they expected a person warranted a longer-term relationship with the service (greater than six months), then one of the three clinical nurse specialists attached to the team assumed the care role. Invariably the team directed those with a diagnosis of schizophrenia down this route. During my negotiation of access to the site, the Assistant Director of Nursing (my gatekeeper) and the consultant psychiatrist, recommended that if I wished to be an active participant in the care of people diagnosed with schizophrenia, then I should enter the field in the clinical nurse specialists' role, as this best exemplified the nurses' involvement in care. This became the basis for my engagement.

The three clinical nurse specialists took referrals of new service users on a rotational basis. To build up a cohort, for a period of six months, I agreed that I would accept all of the service users making the transition to clinical nurse specialist care irrespective of their diagnosis. In addition, to capture a wide range of experiences, I accepted some service users from other members of the team, who they thought might add to my experience. These service users represented those on a continuum of engagement with the service over a lifetime of the diagnosis. By the end of my fieldwork, I accepted 15 people ordinarily allocated to clinical nurse specialist care. Eight of those received a medical diagnosis of schizophrenia from the ICD 10 categories F20-29. My colleagues expected that more people would enter clinical nurse specialist care; however in their opinion, that year saw fewer referrals than other years. Based on the experiences I witnessed during the observation phase, I did not anticipate the implications of accepting the new referrals. My projected three-day week involvement with the team quickly became four and regularly five days per week. During the fieldwork, some unforeseen circumstances resulted in clinical nurse specialists being absent for periods and I plugged some of the gaps that arose from time to time.
In a typical working week, the clinical nurse specialists, like all of their other nursing colleagues worked a 37.5-hour week. They generally worked one weekend in four “on call” and received time in lieu for “on call” duties they worked. The allocation of new service users to clinical nurse specialist care happened in rotation. The effective outcome of this allocation process meant that service user allocation became a lottery as to which clinical nurse specialist that person worked with. At any given time, each clinical nurse specialist had 55-60 people allocated to her care. Dependent on service user needs, clinical nurse specialist contact with people varied from once or twice per week to three weekly, with clinical nurse specialists endeavouring to see each person at least once in a three-week period. They kept track of intervals between contacts using a log. Where difficulties arose in making face-to-face contact, the nurse used telephone contact to ensure intervals did not exceed the timeframe.

The clinical nurse specialist spent approximately 22 hours per week on direct interaction with people in their care; either face to face or using the telephone. This time also included travelling to and from home and community visits and documenting care. Most of the face-to-face contact nurses made were within a 20-minute drive of the health centre. Contacts ranged from 5 minutes to 60 minutes, lasting on average 20 minutes. The clinical nurse specialists estimated they saw approximately 25 service users per week from their individual allocations.

Nurses' work domains
The focus of my initial observations centred on the work and interactions of the community mental health team’s three clinical nurse specialists, whose role I attempted to emulate. The role appeared to function in two distinct domains, an inter-professional role, located largely within the walls of the health centre and the face-to-face role of interaction with service users and families, at times located in the clinic, but most often located in the person’s home or community.

Domain 1: The inter-professional domain
The inter-professional domain, I found to be bound by formal professional language; often framed in technical jargon. In this domain, the language used emphasised ‘symptoms’, ‘side-effects’, ‘absence of coping’ and ‘risk’. Care was largely systematised according to diagnosis and treatment. The team had established protocols for monitoring the extent to which ‘illness’ and ‘treatment’ compromised physical state, such as weight gain, blood monitoring and vital sign recording at set intervals. Nurses performed all these ‘routine’ tests.

Interactions between staff happened in rooms and corridors, in small groups and large groups. In many situations, the consultant relied upon nursing staff as the eyes and ears of the service. Here, nursing observations during their interactions received priority as most reliable. I witnessed early in the fieldwork, when a registrar expressed an opinion that he did not believe one of the service users, Brian, was actively hearing voices, I recounted my visit to Brian’s house two days earlier. I reported that when I entered radios blared in three different rooms and the television was on in the kitchen. Brian kept the radios on for the duration of the visit. I surmised that Brian used these as a strategy to cope with voice hearing. In response, the consultant advised the registrar to record the probability of voice hearing in Brian’s case notes.
The team placed great emphasis on making contact with people, effectively ensuring the ‘laying of eyes on the body’. The clinical nurse specialists emphasised the importance to me of ensuring that I document my interactions and encounters. It resembled compiling an audit trail in the event of an untoward event; recording evidence that the team was not remiss in allowing a service user to ‘fall through a crack’. At each encounter, the consultant expected me to monitor mental state, the effects of treatment and the effective use of medication. I should assess the person and feedback to the team. Crisis management was a regular component of the role.

In this domain, nurses had a poor tolerance for people perceived as ‘wasting time’; who did not fully engage with the service. The team had a protocol, whereby if a person missed three appointments at outpatients or with their ‘key nurse’, they received a letter, informing them of their discharge should they not contact the service to make and keep a new appointment. Failure to respond meant automatic discharge. The consultant explained the rationale for this policy simply; staff time was a resource, resources were valuable, missing appointment was a waste of a resource, there were many people wanting to avail of the resource who had to wait. If the person did not wish to avail of the resources then they should seek to make provisions for their care elsewhere and free up service resources.

**Domain 2: The face-to-face role with service users**

As I took on the full participant role, I noted that my work with service users became a largely solitary endeavour, located within the person’s home and community. Despite the supportive nature of the people I worked with, I still felt alone in my working style. Unless I chose to raise an issue no one on the team was concerned with the content of my interactions with service users or the nature of my practice. I did seek out a person external to the team, based at Rathmullen, to provide clinical supervision for my practice, but despite two people initially indicating they would be prepared to enter into a supervision relationship, neither took on the role. I discussed the matter with the assistant director of nursing, his suggestion was that I should use the CNS team in this role, observing that it was the way they problem-solved. However, I found the clinical nurse specialists as a group, did not discuss the ‘mundane’ workings of care. Their discussions only centred on major problems and crisis management.

When routinely working face-to-face, the language used stood out. This was a domain negotiated often in a politically correct and carefully constructed language that endeavoured to be sensitive and trying to maintain a professional persona. I noted especially the opening of phone conversations, ‘Can you talk?’ explained by my CNS colleague Angela as important, as most service users would not conduct discussions relating to the mental health in the company of others.

The CNS role was largely a brokerage or intermediary role, acting as a link between service users and other professionals, noting observations, communicating events. On occasion, these conversations became exercises in ‘translating medicalaese’, explaining to the person the changes made to treatment at the most recent visit to the outpatient clinic. The role also served as liaison to the Community Welfare Officer and social welfare, and the local pharmacist, delivering new prescriptions, sometimes collecting medication and delivering it to homes.
The emphasis in the face-to-face interaction concentrated upon reinforcement of ‘what keeps you well’. Invariably in the interaction, at some point the conversation always moved to include a ‘check in’ on medication use. Whether the person was maintaining the dosage as prescribed, whether they filled prescriptions. Medication management strategies focused on a ‘motivational interviewing type’ approach, talking up the benefits of medication, de-emphasising the negatives of the adverse effects.

Nurses maintained an educative role in interventions; three particular problems fell into the domain of the CNS, managing sleep problems, managing anxiety and panic, and anger management. In the top drawer of the filing cabinet, for each of these problems the clinical nurse specialist kept a folder of literature, hand-outs that they worked their way through alongside the person explaining the best ways to cope.

Yet alongside these formally framed roles, there was a less formal side, where the language became less stern and less officious; tones became softer. It became the language of friends. This was where the true long-term relationship flourished; in Angela, the language exuded praise and positive affirmation, energy and enthusiasm. Her use of language sought to find the strengths that people had to keep them well. In this guise, Angela became mentor and guide, confidant, friend, the person to call in a crisis.

A good ethnography should provide a description of the field that allows a reader to place him/herself at the heart of the study, seeing the lives of those concerned as though present in time. In this chapter, I have tried to present the field in the context of the policies responsible for the foundation of community mental health care that prevailed during the study. The chapter provides a description of Glenvilly, the location for the fieldwork and introduces the characters central to the writing of the ethnography. Here, I have tried to outline the way psychiatric nurses worked within the community mental health team, the time they spent in contact with people and the relationships they had with colleagues. In addition, the chapter provides detail on the forms of care and treatment in which nurses engaged and the way they managed their workload.

In the following chapter, I present the central construct to emerge from this ethnography, the ‘professional dissonance’ that nursing care working with the diagnosis of schizophrenia creates. In addition, the chapter provides background on Festinger’s (1957) theory of cognitive dissonance, and its later developments, of which ‘professional dissonance’ is a variant.
Chapter 5: Cognitive Dissonance: A Primer

‘A cognition: any piece of knowledge that a person may have. It can be knowledge of a behaviour, knowledge of one’s attitude or knowledge about the state of the world’

(Cooper 2007:6)

The Central Construct

This autoethnography set out to explore the role of the psychiatric nurse working with people with a medical diagnosis of schizophrenia. I did not set out to write a thesis on dissonance about schizophrenia. However, as the analysis of data deepened, the central construct to emerge in this ethnography was professional dissonance. The notion of cognitive dissonance first emerged in the analysis when I sought to find ways of understanding what underpinned individual nurses’ responses in particular situations. I found it hard to explain how different patterns of actions emerged when two nurses working with people diagnosed with ‘schizophrenia’ attempted to find solutions to similar problems that they were confronted with, yet the solutions they offered were very different. I also felt I personally struggled to cope with trying to hold two conflicting perspectives on aspects of the ‘schizophrenia’ diagnosis, both considered right by experts of varying opinion, but each opinion at times advocating a contradictory standpoint. In light of these two fundamental problems, seeking some form of explanation for the behaviours, my reading brought me to the seminal text written by Elliot Aronson, ‘The Social Animal’ (Aronson 2007), then in its 10th edition. In accounting for the actions of individuals, Aronson’s explanations of the theories of Leon Festinger on dissonance appeared to provide the best explanation for the variances and my own experiences. After the initial encounter with dissonance theory in trying to explain behaviours, my autoethnographic analysis moved to different areas and I let the notion lie. It was only after two significant rewrites of the data analysis that I identified how significant my actions in clinical practice were driven by my responses to dissonances that I experienced. It was only at that point that the crystallisation of the core construct of ‘professional dissonance in schizophrenia’ emerged.

Taylor (2007:89) defines professional dissonance as the feeling of discomfort that emerges when conflict arises ‘between professional values and job tasks’. Professional dissonance is a specific application of Festinger’s (1957) Cognitive Dissonance Theory. Festinger used the term cognitive dissonance to describe the uncomfortable feelings people experience when holding simultaneous but conflicting cognitions. Dissonance theory belongs to a group of cognitive consistency theories, which see the individual “as an internally active processor of information who sorts through and modifies a multitude of cognitive elements in an attempt to achieve some type of cognitive coherence” (Tedeschi et al. 1971:685). Cognitive dissonance arises when there is an ‘inconsistency of importance’; when we are forced to hold two contradictory ideas simultaneously. These contradictions result in mental discomfort or anxiety; with the person experiencing sympathetic arousal, unease and feeling torn and unsure.

43 This theory developed from the book ‘When Prophecy Fails’, Festinger et al’s (1956) analysis of a UFO cult’s experiences when ‘non-cataclysmic’ reality clashed with cult members fervently held ‘beliefs’.

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of the path to take. This ‘arousal’ results in an emotional response, which may manifest as regret, guilt, shame, anger, embarrassment, distress, annoyance with one’s self or despair.

In the field of cognitive dissonance, various re-conceptualisations of dissonance theory have taken place over time, through psychologist exponents such as Aronson, Cooper and Fazio. Two elements are at the core of all of these conceptualisations. The first is conflict, the result of clashing expectations, beliefs, attitudes or behaviours. The second is tension, which arises when we deem the contradiction important to our value system.

Dissonance presents in two forms, hedonistic dissonance where the individual’s behaviour becomes self-destructive and moral dissonance, where the behaviour has action or effect on others. As a phenomenon dissonance according to Cooper (2007) has magnitude which occurs when the conflict between belief and action is important to our sense of who we are. Cooper (2007) identifies that the more discrepant a cognition is, the greater the dissonance a person experiences, particularly when the dissonant cognition is highly important to them. He illustrates this with a dissonance magnitude equation as follows:

\[
\text{Dissonance magnitude} = \frac{\text{Sum of all dissonant cognitions} \times \text{importance}}{\text{Sum of all consonant cognitions} \times \text{importance}}
\]

The theory predicts that when people are forced to support a contrary perspective or when the reward they receive for supporting a contrary perspective is low, the dissonance they experience will be greatest. In the film archive of his studies, Festinger states that when a person is forced to compromise his/her beliefs, he/she comes to believe “in and love the things you have to suffer for” (Zimbardo 2010).

There is limited discussion of professional dissonance in health literature. De Vries (2008:569) argues that cognitive dissonance has implications for ‘a wide variety of professional situations’ in health, where ‘practices and principles are in conflict’ and that dissonance theory can explain the emergence of ‘undesirable’ clinical practices such as slowed responses to cardiac arrest in cases perceived to be ‘hopeless’. Quill et al (1999:10) also describe professional dissonance in healthcare, seeing it as an outcome of incongruent ‘policy mandates’, whilst in nursing, Nowak and Bickley (2005) use the concept to describe nurses’ reactions to changes in management structures in Australian healthcare. They identified three types of dissonance amongst nurses, ‘professional dissonance, career choice dissonance and ideological dissonance’ (Nowak & Bickley 2005:3). Thus far in mental health considerations of professional dissonance are limited to the work of Taylor and Bentley (2005, 2007), who use the concept to describe social workers’ responses in day-to-day struggles with complex value-laden decisions, such as pressure to diagnose reimbursable conditions, coping with staff shortages, the right to refuse treatment and involuntary interventions.
Dissonance Theories

In a revision of the original work Aronson (1968) proposed the ‘Self-Consistency Theory of Dissonance’. He considered that ‘the self’, needed to be included in dissonance, as people create expectations of how they expect themselves to behave. According to Aronson (1968), without the involvement of ‘self-concept’, who a person sees himself or herself to be, there would be no dissonance; dissonance arises when the person has to break the expectations of themselves. In self-consistency theory, we are motivated by the desire to be ‘right’ or ‘good’ on a constant basis. Our core values reflect how we see ourselves; how we ‘label’ situations, as either ‘good’ or ‘bad’ affects the way we experience emotions. Our beliefs about these ‘labels’ govern our emotional response, as either strong or weak emotions. Very negative emotions are aroused when we see the involvement of the ‘self’, the notions that ‘I am wrong’ or ‘I am stupid’ acting to provoke strong dissonance. In this regard, ‘hypocrisy’, when the individual is confronted with ‘the discrepancy between what they practice and what they preach’ is a strong force for dissonance (Aronson 2004:353).

In the ‘New Look’ Theory of Dissonance Cooper and Fazio (1984) consider that for a person to lessen the dissonance they experience, they need a ‘cognition’ related to that dissonance to repair the inconsistency. They can do this by either changing how they view the event or change their attitude to the event. How people view a situation, determines the type of dissonance they experience. In the ‘Self-Standard Model of Dissonance’, Stone and Cooper (2001) consider that we experience dissonance when we fail to adhere to standards set by us and for us. This standard is usually primed by the social situation that provokes the dissonance. They identify two types of standards to account for the way we experience dissonance:

i. Normative standards: those based upon guidelines, rules and regulations

ii. Personal standards: standards based upon personalised ideals

They reason that if people view a situation in a context related to ‘them’, then they are more likely to judge the situation using ‘personal’ standards. Where people view situations using a ‘rest of the world’ perspective, they are more likely to use ‘normative standards’.

It is possible for a person to experience dissonance even when he or she does not perform the dissonant act. In accounting for this, Norton et al (2003) introduced the concept of ‘vicarious cognitive dissonance’; simply put when we witness others of our peer (social identity) group engaged in acts that conflict with our values we can experience dissonance. We are subject to dissonance, even though we are not responsible for that act. Cooper (2007:128) believes that ‘social identity theory’ is at the root of vicarious dissonance. He believes people are motivated to reduce dissonance more when they experience it as the result of the behaviour of their own social group. The person feels responsible because of his or her close connection to a group member; it resonates with the person as ‘my’ fault. In these situations, the more an individual identifies with the group, the greater the amount of vicarious dissonance they experience.

Measuring Dissonance

Cooper (2007:54) notes that the “process of dissonance arousal is difficult to see”. Croyle & Cooper (1983) were the first to measure dissonance directly using physiological markers, as in
the galvanic skin response used in lie detectors. As in the instance of lying, the physiological response results in increase in perspiration, measured longitudinally in pre- and post-exposure to dissonant events. The hope was that in finding a way to measure dissonance the person may be able to reduce dissonance by challenging the cognition. The reality is, in real life situations the capacity to measure the extent of dissonance has proved more difficult.

Outside of the tests for physiological responses to dissonant situations, there is little work on the measurement of dissonance. Cassel & Chow (2002) designed The Cognitive Dissonance Test (DISS) based on Festinger theories and utilising an approach similar to “free association” process popular in psychoanalysis. The purpose of the test is to help the person identify areas of dissonance that are located deep in the unconscious memory. It covers 200 true/false questions divided into two sections (i) internal and personal, and (ii) external and impersonal. Each section has four subsections that ‘cover the major areas of one’s life space’ with 25 true/false statements designed to assess the type of hurt the person experiences (Cassel & Chow 2002:1).

Culture types and dissonance

Miller (1984) identifies two distinct cultural perspectives relating to dissonance, agentic and holistic. Agentic cultures, he defines as those characterised by individuals who in their actions are responsible for their own outcomes. In an agentic culture, people see themselves in control of their actions and responsible for their behaviour. Miller (1984) accords that in these cultures people make attributions based on the assumption that the traits and dispositions of an actor are responsible for behaviour. He categorises North American and Western European culture as agentic. In contrast, where cultures are governed by the view that outcomes are not the function of individual action but are a joint function of interrelationships, roles and social obligations, he deems these holistic. According to Miller (1984), people in holistic cultures view behaviours as embedded in relationships with significant people. The holistic culture places an emphasis on harmonious relationships. It prioritises group values, such as those of family, over those of the individual actor. He identifies the cultures of East Asia and India as examples of holistic culture. It is important to note here that the interpretation of ‘holistic’ as related to culture types, should not be confused with the use of ‘holistic’ as applied to nursing practice and concepts of care.

Cooper (2007) identifies that a principle of underlying western culture is the need to be true to the self; people need to act consistently with their inner thoughts and feelings; people should say what they believe and believe what they say. In far eastern cultures however, the harmonic flow of interpersonal interaction is an equally important component of the self. Marcus and Katayama (1991) identify that in these holistic (interdependent) cultures saying what one believes and believing what one says is more complicated. Accordingly, they describe dissonance as a form of an internalised conflict, a struggle between agentic and holistic selves. In holistic culture, the ability to create harmony and act for the good of people with whom you are connected is as important to the interdependent self as any personal belief, attitude or trait. People in holistic cultures form their values based jointly on how they judge the worthiness of their individual disposition and their ability to maintain pleasant and harmonious relationships with the connected others. The presence of a universal motivation to reduce dissonance is questioned, as Egan et al. (2007) believe they have identified the presence of dissonance in monkeys. Despite this, Markus and Katayama (1991) argue that dissonance reduction is not a
'universal motivation' and put forward the hypothesis that it may be the phenomenon restricted to agentic cultures, for example Western Europe, United States, New Zealand and Australia. This aspect does not account for actions such as ‘hara-kiri’ in Japanese culture, which might be considered as an ultimate resolution of dissonance. Heine & Dehman (1997) however do accord a greater propensity for the phenomenon in western culture.

**Status, education and dissonance**

Possible reasons emerge from research into cognitive dissonance, which shows that from a cultural perspective, both status and education contribute to the level of dissonance that people experience (Cooper 2007). People with higher social and economic standings have greater difficulties with the choices they make by comparison with those of lower standings. Cooper (2007) argues that people in these categories need to be surer that they make the right decision. Snibbe and Markus’ (2005) experimental research shows that within a culture, when taken as a measure of socio-economic status, educational attainment relates the level of dissonance people experience. They believe that two models of agency emerge, relative to the level of attainment. Comparing European American participants levels of achievement across two categories, those completing education at high school and those progressing to degree levels, they identify those with greater the level of educational attainment, struggling with dissonance more when faced with decisions. They suggest that those with the lower level of educational attainment ‘may have a more balanced view of choice, and simply a more flexible emotional response to not getting what they want’ (Snibbe & Markus 2005:716). Although this experimental research may show an effect of education level and socioeconomic status on dissonance, it fails to explain the dissonance of the unemployed single mother with low educational attainment given a dual diagnosis of schizophrenia and borderline personality disorder, who encounters diverse responses ranging from supportive to prejudicial and stigmatising from staff when she presents in distress, not knowing what response she will receive from the different people she encounters. Here the dimensions of time and context of experience have far greater influence on dissonance than educational attainment.

**Dissonance Reduction**

Dissonance causes arousal, but an arousal stimulus must be negative for dissonance to occur. In the original theory, Festinger (1957) hypothesised that when dissonance occurs, people need to reduce it, but before people will change their cognitions, there needs to be both arousing and aversive consequences. They can reduce dissonance by looking ‘outside’ of themselves to incentivise holding on to their belief. They can also change their attitude, behaviour or perception of the situation. However, sometimes, it is easier to create a justification for the aberrant cognition, than to challenge the cause of dissonance. People generally attempt to cope with dissonance in four ways:

i. **Selective exposure:** people only seek out information that supports their standpoint

ii. **Selective attention:** people only pay attention to the arguments that support the action or outcome that they desire

iii. **Selective interpretation:** people interpret information or facts as valid only if they are consistent with their own beliefs

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iv. Selective retention: people only hold on to the information which supports their particular standpoint value or belief

In dissonance, if we can change our attitude towards the object of dissonance, then our discomfort decreases and the dissonance abates. Cooper (2007) argues that simply admitting to feeling ‘uncomfortable’ from your actions can lower the need to do anything. He identifies that two ways of coping with dissonance emerge, self-affirmation and self-consistency. The self-affirmation view of dissonance reduction argues that a person does not need to change his or her attitude to a problem but can counterbalance dissonance by carrying out a good act (distraction) (Steele 1988). However, Stone et al (1997) argue that people do not resolve the discrepancy between their behaviour and their self-standards using this approach; it only allows people to avoid dissonance.

Cooper (2007:81) believes that self-consistency is important in the concept dissonance. Acting inconsistently produces consequences for the actor. When we have inconsistency, there are two possible outcomes, ‘unwanted consequences’ or ‘no unwanted consequences’. Dissonance grows when ‘unwanted’ or ‘aversive’ consequences result from behaviour. These inconsistent cognitions interfere with people’s ability to act, but there are conflicting views on why this happens. Festinger (1957) believed this mechanism was hard-wired, effectively part of our genetic make-up. On the other hand, Harmon Jones (1999) believes that people adopt positions in the world that make it easier for them to act and to be able to avoid ambivalence and conflict. People need to have an unequivocal way of acting in social and physical environments; inconsistency interferes with this. However, inconsistency on its own is not enough to cause dissonance; there needs to be aversive consequences (Cooper & Fazio 1984). Festinger (1957) believed that bad things do not have to happen to create dissonance; ‘aversive consequences’ just have to be ‘foreseeable’. This may in part be explained by the notion of ‘anticipated regret’, a fear that in making the wrong choice other alternatives may be precluded (Tykocinski & Pittman 1998).

In the context of this thesis, working with people diagnosed with schizophrenia’s has the potential to evoke dissonance for a psychiatric nurse. The following are some statements that may help explore dissonance in more depth

i. Ethically, a cardinal principle of nursing is ‘in first instance do no harm’ (O’Neill 2002).

ii. The diagnosing of schizophrenia is damaging for a person in the consequences of labelling and stigmatisation (Barker et al. 1999).

iii. When people given a medical diagnosis of schizophrenia are treated with anti-psychotic medication long term, they have less favourable outcomes than those not treated with medication (Harrow & Jobe 2007:406).

iv. As a part of a social control role, psychiatric nurses must encourage, coerce or possibly restrain people given a diagnosis of schizophrenia and force them to take anti-psychotic medication (Morrall & Muir-Cochrane 2002).
When we consider the ethical principle of beneficence evident in the first statement; mental health nurses should not be involved in damaging practices. Doing so, creates an "inconsistency of importance", the first condition for dissonance. The second condition is "mental discomfort". Here created by the awareness of involvement in potentially damaging practices, such as the conflict arising in statements three and four, using medication has poorer long term outcomes than not using it but a part of my job is to coerce people into taking it. This can create tension and make the nurse feel uncomfortable and agitated, unable to decide. This can perhaps be accompanied by sympathetic arousal, and emotions such as shame, regret, embarrassment, anger or annoyance with oneself, remorse, uneasiness and despair.

Festinger's (1957) theory argued that when people experience dissonance, they seek to reduce their discomfort by changing their attitude, behaviour or perceptions of the topic. In doing so he believed that they may also attempt to justify their action, or shift in their attention away from dissonant notions using distraction. As an example of this, a person may voice protest against the use of the label 'schizophrenic'; alternatively, s/he might choose to use less stigmatising terminology, such as psychosis. They may also justify their continued support for a colleague using the term schizophrenia as playing along with particular courses of action because they feel they could lose their job if they challenge or confront the person. In their attempts to reduce dissonance, they may encounter obstacles and some of the strategies used may only serve to cause new dissonance, such as protesting or criticising decisions may be dissonant with their perception of themselves as a loyal employer or colleague. Even in this simple example, it is possible to see how a highly complex dissonance can result for a nurse and can generate the feeling of 'being stuck between a rock and a hard place'.

Preface to the analysis

The work I present from here on, details some of the complex dilemmas posed for me, when working with people given a medical diagnosis of schizophrenia. It examines the problems that occurred when my value system and others value systems did not fit with the wider accepted discourses in the clinical environment. In particular, it explores attempts to cope with professional dissonance, where conflicting theories and evidence in schizophrenia, directly influences the outcomes of care for people given the diagnosis.

The findings and analysis that follow over the next three chapters take their form from the core conceptualisations of dissonance theory, based around an account of where the inconsistencies emerge in schizophrenia, the feelings these evoke and the emotional response they generate. They illustrate the efforts made to reduce dissonance, the obstacles to reducing it and where applicable the new dissonance arising on foot of these efforts.

The first chapter of analysis (chapter six) examines dissonance resulting from the language of schizophrenia, vicarious dissonance and the dissonance that being forced to work within finite resources creates. I also look at how a professional constructs an individualised model of the person given the diagnosis, based around his/her value and belief system in an attempt to reduce the dissonance schizophrenia theories create. The second chapter (chapter seven) explores dissonance caused when working with people in clinical practice, where the service works to create a set of responses from the person with which they can work. This process involves 'creating a docile body' using 'correct training'. The final analysis chapter (chapter...
eight) examines the aspects of dissonance reduction in the context of the use of power and discretion. I explore how individual staff members exercise both of these factors in reducing dissonance.

The ethnography primarily centres on the stories of four people, given a medical diagnosis from the ICD-10 categorisation of ‘schizophrenia, schizotypal and delusional disorders’ (F20-F29) and the multidisciplinary team members directly involved in their care. It tells the stories from both their individual perspective and from ‘behind the scenes’ in the discussions within the team and my own internalised perspectives in my interactions. In the instance of three of the four stories, these were the people that I worked with most closely over the duration of the fieldwork, with whom I had the most prolonged engagements and whose care came to exemplify the challenges that I faced when working in the area. They are Andrezej, a nineteen-year-old Polish Roma emigrant diagnosed in his homeland with paranoid schizophrenia at age 17; Sarah, a 42-year-old woman diagnosed with schizoaffective disorder at age 19, and Greg a young man given a diagnosis of paranoid schizophrenia. The fourth story is that of Aisling, 26, diagnosed with paranoid schizophrenia five years previously. Aisling’s story represents a longitudinal account, exemplifying the challenges and tensions of care within the multi-disciplinary team over the entire year of the fieldwork. Aisling’s account in particular details the experiences of care taken from both sides of the experience, the field notes from within team meetings supplemented with interview material where Aisling detailed her experiences of working with the psychiatric nurses.
Chapter 6: The dissonance caused by language and holding different beliefs

This chapter explores aspects emerging from the data analysis. The first theme relates to how the language and symbols used in ‘schizophrenia’ create ‘inconsistency’ for service users, families, nurses and other members of the multidisciplinary team and result both directly and vicariously in dissonance. It explores how these inconsistencies created ‘discomfort’ for me and triggered emotional responses resulting in dissonance. The chapter also explains how I attempted to reduce the dissonance I experienced, through creating a personalised interpretation of schizophrenia around the people I was working with. It concludes with an exploration of dissonance caused when nurses need to manage care within the contexts of constraints on time and money. The analysis begins with the dissonance the word ‘schizophrenia’ creates.

Language and the seeds of discomfort

As identified earlier, a central component to cognitive dissonance is the concept of ‘inconsistency’, which refers to a person being confronted with two equal but opposing cognitions being valid. For me, this inconsistency began before I entered the field, as I tried to negotiate access to the site. It surrounded the problems of language and the very word ‘schizophrenia’. Having selected an area for the fieldwork, I met with its Assistant Director of Nursing (ADoN), Sean, to discuss my research proposal and access. He identified what he saw as a problem with my proposal, the term ‘schizophrenia’. He stated that the multidisciplinary team in the proposed site did not use the diagnosis often; he stated that they preferred to use the term ‘schizophrenia spectrum’. I was embarrassed by this, worried that I had a ‘disconnect’ from the reality of practice and that in my time away from practice mental health teams had ‘moved on’ from the diagnosis of ‘schizophrenia’. However as I joined the team, the reality was all of the discussions surrounding the diagnosis and descriptions of people were in sharp contrast to those expressed by the ADoN. The label of ‘schizophrenia’ was ‘alive and well’ and central to the team’s description of people. Aisling, a service user for five years recalled the experience when the psychiatrist introduced her to the diagnostic label ‘schizophrenia’:

“I told him my symptoms, my delusions as he calls them ... that all sounds insightful but I thought just crazy, so I told him in anyway and he diagnosed me as schizophrenic”

Aisling, Interview

Among my fellow nurses, the language of ‘schizophrenia’ ‘delusion’, ‘deluded’, ‘thought disordered’ and ‘hallucination’ was in routine use. However, I noted contrasting patterns of use in the term ‘schizophrenia’, signifying that a degree of discomfort was present with the language, depending upon the audience and setting. In their face-to-face interactions with people given the diagnosis, I noted nurses rarely used the term ‘schizophrenia’. Their conversational content focused on experiences, symptoms and medication use, without any reference to the diagnosis. Yet, they used the term frequently with family, explaining
behaviours in biomedical terms and symptoms. In discussions during team meetings, staff used the term 'schizophrenia' without restraint.

Nurses, in using different forms of language between those diagnosed and their families can create a barrier between the person and their family. In avoiding the use of 'schizophrenia' terminology with the person diagnosed, nurses engage with that person on a different level to those of their families. This use of formalised, medicalised language with families reinforces the illness narrative, which families come to rely upon and which fashion their view of their relative.

Personally, I had great difficulty using the term 'schizophrenia'. I noted in my interactions that I always used the expression 'the medical diagnosis of schizophrenia'; I refrained from the use of the terms 'hallucination' or 'delusion', instead preferring to use 'voices' and 'strange thoughts', but I was alone in this practice. Goffman (2007) in 'The presentation of self in everyday life' describes how people present themselves in formal arenas where they have influence over others. He describes people as 'actors', constructing performances, paying care and attention to their 'front' stage audience. The observations revealed nurses adopting different 'front' stage perspectives in relation to the term 'schizophrenia' in the presence of service users and families whilst behind the scenes in conversations between themselves and in team meetings differing language was used, as this aside between multidisciplinary team members concerning a woman with a diagnosis of 'schizophrenia' revealed:

"...that one is mad as a hatter"

Field note: Thursday, Week 1

Embarking on the research, I regarded myself as a 'psychosocially orientated' practitioner, with an interpretation of 'schizophrenia' based on a broad range of 'schizophrenia' theories. I was aware of the way I consciously constructed the language I used. I did this in an attempt to accommodate people who might reject the diagnosis. In using the expression, 'the medical diagnosis of schizophrenia', I sought to counteract the unease I felt around the term. This I believed was less stigmatising, and permitted me to work within the system yet at the same time allowed me to distance myself from the medicalised and illness identity that I felt the term projected. This use of language and conflicting theoretical interpretations provided the basis from where my dissonance grew.

The language of diagnostic criteria and dissonance
The accuracy of diagnostic criteria in 'schizophrenia' and the interpretation of these diagnoses by individual psychiatrists generate significant inconsistencies as the following example illustrates. In my time in the field, I encountered only two newly 'diagnosed' people who received the label 'schizophrenia' in the service. The service did not make the diagnosis in either case; the same consultant psychiatrist in a private psychiatric hospital made both diagnoses; both people received the diagnoses of 'paranoid schizophrenia' (ICD-10, F.20). In one case, Philip's, the team's consultant psychiatrist questioned the validity of the private psychiatrist's 'diagnosis', as he had diagnosed Philip with 'Borderline Personality Disorder' when he presented
to the service a year previously\textsuperscript{44}. The consultant stated he believed on that occasion Philip was:

‘... shopping for a mental health diagnosis and that ‘schizophrenia’ he was looking for’.

Will, the occupational therapist who worked as Philip’s keyworker also agreed. Yet Philip who was back in the public service, no longer in receipt of private healthcare cover, was now diagnosed with ‘paranoid schizophrenia’ and prescribed a large daily dose of anti-psychotic medication, that was not impacting on Philip’s belief that there was a conspiracy to harm him. In my work with Philip, he stated he did not believe the diagnosis of ‘schizophrenia’ was accurate. I felt unease at the shifting manner of diagnostic ‘gerrymandering’ and the manner in which ‘private’ psychiatry managed their care whereby ‘private patients’ instantly became ‘public’ responsibility when ‘insurance cover’ ran out and the diagnosing hospital and consultant no longer have any responsibility.

Alone, the inconsistency between individual diagnosticians to provide an accurate diagnosis is insufficient to cause dissonance in this situation. However the negative consequences from inconsistency (Cooper & Fazio 1984), stemming from the actions I was expected to perform in accordance with Philip’s treatment plan, did cause me dissonance. An explanation of this follows.

During the team meeting on Week 38 of the fieldwork, Philip’s consultant psychiatrist felt in view of the fixed nature of his thoughts about the ‘conspiracy’, we should give Philip a trial of the anti-psychotic Clozapine. The consultant’s initial discussion with Philip did not fare well and Philip refused the trial. Because I was Philip’s key nurse, the consultant asked me to try to convince him of the benefit of this trial. I did this, however only with a great degree of inner conflict. I could not reconcile the consultant’s decision to start Philip on Clozapine, in light of the consultant’s expressed belief that Philip did not have a diagnosis of ‘schizophrenia’. The prescribing guidelines for Clozapine are:

“Clozaril is indicated in treatment-resistant schizophrenic patients and in schizophrenia patients who have severe, untreatable neurological adverse reactions to other antipsychotic agents, including atypical antipsychotics.”

(Irish Pharmaceutical Healthcare Association 2011)

Philip did not have ‘untreatable neurological adverse reactions’. If Philip, as the consultant believed, had a diagnosis of Borderline Personality Disorder, then the use of a treatment usually reserved for severe treatment resistant ‘schizophrenia’, constituted an ‘off label’ prescription. ‘Off label’ prescription is the use of a medication to treat a condition for which it is not approved. The indications for the use of Clozapine do not include Borderline Personality Disorder (Irish Pharmaceutical Healthcare Association 2011). I convinced Philip of the need to take medication because it was the function delegated to me; even though I disapproved I told myself I was not responsible for ‘prescribing’ decisions. That remained in the domain of the psychiatrist and nurses do not challenge the consultant’s right to prescribe. Indeed, I witnessed how earlier in the fieldwork my CNS colleague, Regina, having ‘crossed the line’ querying the

\textsuperscript{44} Mental health services in Ireland commonly use the term ‘presentation’ to denote the referral of a person for treatment of a new mental health problem.
consultant’s prescribing practices, immediately self-censured following a stark glare. Recovering, she quickly followed up that:

‘...of course that would always be a medical decision...’

Field note, Thursday Week 28

I resolved that I would not be so foolish as to find myself ‘pilloried’ before the team. In the end, I convinced Philip of the ‘benefits’ of commencing a trial of clozapine. Here dissonance stems from the fact that Philip would be prescribed a medication, whose indication for use was with the most resistant form of ‘schizophrenia’; prescribed by a psychiatrist who believed that the person did not have a diagnosis of ‘schizophrenia’; an action enabled by my powers of persuasion; in circumstances where I did not believe this appropriate. The conditions for cognitive dissonance, namely ‘inconsistency’, ‘aversive consequences’, ‘action’ and ‘freedom of choice’ on my part, grew. The consequence of my action would be Philip’s agreement to a prescription of Clozapine; accompanied by his exposure to the possible adverse effects and potentially fatal consequences. The consequences, well documented by the manufacturers, were in dissonance terms ‘foreseeable’ (Festinger 1957). Following my departure from the field, Philip’s psychiatrist chose not to commence him on Clozapine.

Language, dissonance and working with people
Many critics, as discussed in chapter two, consider the term ‘schizophrenia’ as controversial (Haghighat & Littlewood 1995, Kim & Berrios 2001, Boyle 2002, Davidson 2003, Sato 2006, Haghighat 2008, Sismondo & Doucet 2010). My dissonance surrounding language grew when faced with the need to adopt contradictory approaches with people, because of different evidence-based approaches between psychiatry and psychology. With some people, like Andrezej and Philip, I could talk about ‘schizophrenia’ openly as the background for the interventions I used. However, in other situations, I needed to avoid mentioning the diagnosis,

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45 The belief that I have agency and am capable of influencing the outcome
46 Clozapine is known to have a significant number of adverse effects ranging from very common to very rare:
Very common (>1:10): Weight gain, constipation, hypersalivation, tachycardia, drowsiness/sedation, dizziness.
Common (>1:100): Dysarthria, hypertension, postural hypotension, syncope, urinary incontinence, urinary retention, nausea, vomiting, anorexia, dry mouth, blurred vision, headache, tremor, rigidity, akathisia, extrapyramidal symptoms, seizures/convulsions/myoclonic jerks, ECG changes, Leukopenia/decreased WBC/neutropenia, eosinophilia, leucocytosis, fatigue, fever, benign hyperthermia, disturbances in sweating/temperature regulation, elevated liver enzymes
Uncommon (>1:1000): Dysphoria, Neuroleptic Malignant Syndrome, Agranulocytosis
Rare (>1:10000): Restlessness, agitation, impaired glucose tolerance, diabetes mellitus, dysphagia, aspiration of ingested food, pneumonia and lower respiratory tract infection which may be fatal, confusion, delirium, circulatory collapse, arrhythmias, myocarditis, pericarditis/pericardial effusion, increased CPK, anaemia, thromboembolism, hepatitis, cholestatic jaundice, pancreatitis

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as in the case of Greg where the psychologist was of the view that using the term ‘schizophrenia’ or even ‘psychosis’ would jeopardise his engagement. As a diagnostic categorisation, ‘schizophrenia’ has both positive and negative connotations. Davidson (2003) explains the double edged nature of the problem using the term, although ‘stigmatising’ when applied as a ‘label’ having a catastrophic effect on the person and their family; when used in the diagnostic context he identifies that it opens up avenues for the person and their family to seek therapeutic assistance. I personally saw how it had its uses in affording a person financial stability, as with Brian, a man with a sixteen-year history of the diagnosis, who although ambivalent to the diagnosis admitted:

‘...it qualified him for disability benefit...’

which was more than the standard unemployment benefit. Despite the critiques of reliability considered in the foreshadowed problems, Esterberg & Compton (2009) believe retaining the diagnostic term can improve the reliability of clinicians diagnoses and we need to hold on to the diagnosis as it offers a universality of understanding acting as a reference point for engagement, discussion and research.

The language of ‘schizophrenia’ and the responses of people to the term, creates situations where nurses need to be able to tolerate ‘inconsistency’ in the way they work or experience dissonance if they cannot resolve inconsistencies. Shifting attention away from a subject is a simple way of reducing dissonance.

From a dissonance perspective, the language of ‘schizophrenia’ has consequences that are both ‘foreseeable’ and ‘concrete’. As seen in the Japanese experience (Sato 2006), the team did not discuss a formal diagnosis of ‘schizophrenia’.

The irony was I felt hypocrisy with my stance on not using the term. When having the diagnosis ‘out in the open’ working, I noted the sense of relief in how it was a:

‘...liberating experience with the comfort that the diagnosis brought. It gave a reference framework and a comfort, rather than trying to avoid the 'S' word all the time. It put me in a place where my knowledge could be brought to bear on fixed areas...’

Field Note: Monday, Week 40

Andrezej did not resist the term in our conversations, in fact he would use the term himself. I felt this took pressure off me when it came to interactions. I did not have to struggle to find or avoid words. In Andrezej’s case I could talk to him about the challenges that having the diagnosis presented and even how the legitimacy of the diagnosis was challenged. I felt I could apply my ‘expert’ knowledge of the medical diagnosis and Andrezej’s acceptance I felt gave me a platform to build upon. I felt comfortable talking about what was happening to him in the context of others who shared his experiences and how they coped with the difficulties he experienced. My ‘professional’ vocabulary was geared up to talk about ‘schizophrenia’ using the term as a common reference point. I must acknowledge, however, that Andrezej’s lack of challenge to the use of the diagnostic term did not mean acceptance of treatment as prescribed by his consultant psychiatrist or effective engagement and collaboration with me.
Reflecting on my actions, it did not appear to matter to me whether the person had accepted the diagnosis of ‘schizophrenia’ or not. As long as the term was in the open and people were not confrontational about it, that seemed all that mattered to me. Without the diagnosis as a barrier to my work, I could ‘normalise’ the experiences of ‘schizophrenia’ (Kingdon & Turkington 1991, Kingdon et al. 1994). Using the diagnostic term ultimately made me feel more comfortable with Andrezej or Philip. I was happy; I was in ‘my comfort zone’.

The inconsistencies arising from language use extended into the way I needed to work with people. The example of Greg illustrates this best. The consultant diagnosed Greg with ‘paranoid schizophrenia’. Greg firmly believed that as a part of a conspiracy, he was destined to die in three months. Greg did not accept the diagnosis of ‘schizophrenia’, yet ironically, Greg was the person who most actively engaged with me. Following his decision to discontinue antipsychotic medication, the team decided that a cognitive approach, to be developed by the clinical psychologist, would be worth trying in an attempt to help him cope with his strange thoughts. Using this approach, the team’s clinical psychologist, concluded that maintaining Greg’s engagement working cognitively, and getting Greg to recognise that his thoughts were strange (developing insight) was the most important goal on which we could focus. She recommended abandoning the terms ‘schizophrenia’ and ‘psychosis’, as she felt these would deter his engagement. This meant that on one hand, when the psychologist and I discussed Greg, we spoke in the language of ‘schizophrenia’ but when I crossed the threshold of his home, I needed to engage with a completely new vocabulary, switching on and off as the location dictated.

In light of the earlier discussions, you might consider that I was finally getting what I wanted, a capacity to communicate in the terms that I hoped for, but this only served to generate a new round of dissonance. Although I was familiar with the theories underpinning the psychologist’s approach I had no practical experience of the interventions. I was embarrassed and annoyed with myself and questioned which was better, an approach using medications with a team skilled and experienced in their use or an unskilled practitioner trying to develop new skills using the person as a subject? Working with Greg represented a serious challenge having no reference point from which to engage. Ultimately, my reference point with Greg became the ‘distress’ arising from his ‘memories’, the word he used to explain the strange thoughts he had surrounding the ‘conspiracy’ he believed he was living within. Our intervention would be a gradual process in building insight and provide a platform to use ‘behavioural experiments’.

47 Normalising is a key element of Kingdon and Turkington’s (1991& 1994) approaches to working with psychosis. They use it to explain psychotic events by ‘decatastrophising’; placing psychosis at the end of ‘normal’ behaviour, to help the person feel more normal and less isolated. It also provides a rationale for CBTp interventions.

48 The clinical psychologist used the term ‘cognitive interventions’ to describe her way of working in deference to ‘cognitive behaviour therapy’ as it did not conform to prescribed ways of working with this approach.

49 The processes of thought mapping and behavioural experiments are considered essential in working with cognitive behavioural therapy interventions in psychosis and are regarded as key factors in enabling a person change their understanding and beliefs about their thoughts (Grant et al, 2010)
After six weeks working, Greg began to 'question, if his 'memories' were indeed false, possibly showing 'insight' into their nature.

**Language: a mother's understanding of the diagnosis and a nurse's attempt to cope with resulting dissonance**

Working with family members can also cause dissonance because of the need to navigate the use of the term 'schizophrenia' appropriately. The following episode from an outpatient clinic illustrates this. At the end of the clinic, Angela one of the Clinical Nurse Specialists on the team, spoke to the consultant psychiatrist over an issue that arose whilst recruiting participants for a psycho-education programme for relatives with family members diagnosed with 'schizophrenia'. Clearly annoyed, she explained how she phoned the mother of a young man diagnosed two years previously, inviting her to the forthcoming sessions. The mother appeared shocked and angry at Angela's approach. She maintained that nobody ever mentioned to her that her son had a diagnosis of 'schizophrenia'. Embarrassed by the event, Angela admitted she was very unhappy with what transpired. Angela was annoyed and angry at finding herself in that position, as she believed that the family already knew the diagnosis.

An essential inclusion criterion before inviting a family for participation in the programme was discussion of the diagnosis with the family. Prior to initiating contact with a relative, the consultant completed a referral form. It had a tick box, for completion by the consultant psychiatrist, which specifically asked whether the psychiatrist discussed the diagnosis of 'schizophrenia' with family. Angela recounted her conversation with the young man's mother:

"... she wanted to know why I was ringing her ... it was as though she had heard the word for the first time".

The consultant replied that he was certain he discussed the diagnosis with the family:

"... I'm sure I discussed schizophrenia spectrum disorder with them"

He reasoned that the discussion probably never registered as:

"... perhaps, as a mother, she did not 'want' to hear it".

I wondered if this mother believed that 'schizophrenia spectrum disorder' was different from a stigmatised notion of 'schizophrenia' she held. At least if presented with 'schizophrenia spectrum disorder', notionally she did not have a son with 'schizophrenia'. To the consultant psychiatrist the event was a matter of semantics, but to the mother, the word made a world of a difference. The mother's response in this situation lies in the meaning the diagnosis of 'schizophrenia' has for her. After Angela's invitation to the programme, she prepared to face the 'reality' of a son with a diagnosis of 'schizophrenia' and the attendant connotations the diagnosis brought.

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McEvoy et al (1989:48) document the perception that the ability of people to acknowledge illness and the need for treatment is 'usually connoted by the term insight', which early psychodynamic theorists deemed to be 'part of the curative process'. Their study of 52 inpatients diagnosed with 'schizophrenia' concluded that the presence of 'insight' had an independent positive impact on outcome. They recommended using psycho-educational strategies as a means to improve 'insight'.

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Psychiatry's inconsistency in using diagnostic language, coupled with negative outcomes for people given the diagnosis, as shown, creates 'vicarious' dissonance for nurses. There is an increasing view that the medical diagnosis of 'schizophrenia' is not a unitary illness but rather a syndrome composed of subtypes of differing origin (Boyle 2002). Bentall (2003) and Esterberg and Compton (2009) regard it as an experience at the extreme end of a continuum of psychosis. Although not an entirely new perspective, the term 'schizophrenia spectrum' recently emerged to reflect this explanation of the diagnosis (Esterberg & Compton 2009). Reflecting the possibility of both severe illness and mild and non-clinical states under an umbrella term, the 'spectrum' description allows for subtypes that may possibly be linked, due to their clinical appearances or by a shared underlying cause (Esterberg & Compton 2009).

As discussed in chapter two on the foreshadowed problems, the literature reveals similar dilemmas to this emerging in Japan, and in Chinese and Korean societies (Sato 2006). In these societies the simplistic translation of the 'split mind', create a stigma so great that it becomes an illness of which no one speaks its name, with people left languishing in institutions; neither they nor their family knowing the reason for the incarceration. In this ignorance, nobody provides interventions, which might help. The connotations related to the diagnosis of 'schizophrenia' are highly significant. In the 'Elements of Semiology' Barthes (1967) exploring the concepts of 'signifier and signified', predicted that the future of linguistics belonged to 'connotation'. Chandler (2007) describes meaning as comprised of two categories, 'denotation' the literal definition of a word, often the obvious or common sense interpretation and 'connotation'. 'Connotation' refers to the socio-cultural and personal associations a person makes in relation to that word or signifier. When we first encounter a denotation, we also receive an introduction to the 'connotations' linked to the values and beliefs that dominate that culture (Silverman 1983).

As 'connoted', the word 'schizophrenia' serves many purposes other than diagnosis or stigmatization as referred to earlier. People use the diagnosis for political struggle and social advantage; as a discursive intervention for reclaiming personal worth; as a way to demonstrate solidarity with others so diagnosed and for economic gain (Haghighat 2008). The language used in 'schizophrenia' creates both evaluative and emotional connotations that influence people's responses to the diagnosis and to the person (Haghighat & Littlewood 1995). Although people given a medical diagnosis of 'schizophrenia' can see value in the use of the diagnosis, such as the ability to access treatment, many still see the diagnosis as devaluing. Indeed, Angela could

51 For cultures based upon ideographic forms of writing, the literal translation of 'schizophrenia' to 'seshin-bunretsu-byo' or 'split mind disease' caused inherent sociological problems, as the general population came to accept the categorisation's literal translation as fact. 'Connotations' were particularly important in this instance, as the denotations of Japanese ideographs of 'schizophrenia' evoke a state of 'catastrophic disorganisation' that generated powerful stigma in Japanese society towards those receiving the diagnosis. This caused practical problems for psychiatry in Japan as psychiatrists became reluctant to use the diagnosis. As a direct consequence, people were left to languish in institutions without receiving a diagnosis, treatment was provided without rationales or no treatment was provided at all and families did not get explanations of problems (KIM, Y. & BERRIOS, G. E. 2001).
foresee the consequences of inadvertently ‘breaking bad news’ to a parent, and the team had designed the referral form specifically to avoid this form of disclosure. The inconsistency in the use of diagnostic categories, coupled with an aversive outcome for which the nurse was responsible, namely the mother’s distress, serve to create dissonance. In the ‘New Look’ approach of cognitive dissonance, Cooper and Fazio (1984) argue that a person needs to alleviate dissonance by a ‘cognition’ related to the dissonance. They identify that if an outside agent can be seen as responsible or attributable for the inconsistency, then it is possible for the person to deny the consequence, thereby alleviating the dissonance. It may be that Angela’s questioning of the consultant was an attempt to reduce dissonance.

Angela’s engagement with the mother, illustrates the difficulties that arise in inconsistent use of diagnostic terms that faces nurses in practice. Angela understood that the psychiatrist made and communicated the diagnosis of ‘schizophrenia’ to the family. He indicated as much in the referral form to her. Yet, even post the event, the consultant psychiatrist still discussed his diagnosis in the context of the ‘schizophrenia spectrum’. However, ‘schizophrenia spectrum’ is not a formal diagnosis under either the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) (American Psychiatric Association 1994) or the International Classification of Diseases (ICD-10) (World Health Organization 1992), which represent the formalised language of psychiatry and view psychosis as discrete mental illnesses. The practice of using generic and possibly what people may consider a ‘euphemistic’ categorisations like ‘schizophrenia spectrum disorder’ may be an attempt to avoid the stigmatisation of imposing a formal diagnosis of ‘schizophrenia’. However, what is clear is that its use still results in similar problems and levels of distress owing to the connotations the term evokes. Interestingly, the American Psychiatric Association (2012) in the forthcoming revision to the DSM-V, proposes to use the term ‘schizophrenia spectrum’ as the overarching category for ‘schizophrenia’ and other psychotic disorders.

**Dissonance resulting from the multidisciplinary team's use of ‘schizophrenia’ symbols**

Disseminating written information to people given the diagnosis and family members also illustrates ‘inconsistency’ and causes dissonance. The community mental health team used two publications designed for service users and family members, and with the aim of providing them with an understanding of the ‘schizophrenia’ diagnosis; how the diagnosis is made, the various treatments available and advice on what to expect. The documents were the National Institute of Mental Health (NIMH) booklet ‘Schizophrenia’ (2009) and Elgie et al’s (2004) ‘Discover the Road Ahead: Support and Guidance for Everyone Affected by Schizophrenia’. The inconsistencies arose from the content and authorship of the documents, as I shall explain.

Angela, my Clinical Nurse Specialist colleague, kept a number of envelopes in the top drawer of her desk on a variety of mental health problems; an A4 manila envelope marked in handwriting with the words ‘Schizophrenia Proof’ was one. I noted when other members of the team

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52 Cooper and Fazio’s (1984, p.74) ‘New Look’ model of dissonance states that dissonance occurs when a person is responsible for bringing about an event (personal responsibility) and the negative result or consequence is foreseeable.
needed information to discuss new diagnoses with service users; they came to Angela and copied the contents of the specific envelope.

The 'Schizophrenia Proof' envelope contained the NIMH publication. The NIMH is a part of the U.S. Department of Health and Human Services' National Institutes of Health. The NIMH states that:

‘For the Institute to continue fulfilling this vital public health mission, it must foster innovative thinking and ensure that a full array of novel scientific perspectives are used to further discovery in the evolving science of brain, behaviour, and experience. In this way, breakthroughs in science can become breakthroughs for all people with mental illnesses’.

I felt great unease with this twenty-page document. The NIMH website refers to the document as ‘A detailed booklet that describes symptoms, causes, and treatments, with information on getting help and coping’. The booklet follows the biomedical narrative closely. It identifies ‘schizophrenia’ as a ‘chronic, severe, and disabling brain disorder’ and compares it to lifelong ‘chronic’ physical diseases such as diabetes and hypertension implying an underlying but yet unproven physical cause. It presents a two-page outline on the causes of ‘schizophrenia’, strongly orientated to biological explanations of genetic causation, structural brain abnormality and brain chemistry malfunctioning. The aspects of psychological, social, the role of the environment, intrauterine viral infection, birth trauma and malnutrition receive a 25 word commentary. The booklet dedicates three and a half pages to discussions on medication and despite emphasising that:

‘NIMH does not endorse or recommend any commercial products, processes, or services and this publication may not be used for advertising or endorsement purposes’ (p.22)

Yet, included as special addendum, added in January 2007 between pages 18 and 19, a solitary paragraph states:

‘Aripiprazole (Abilify) is another atypical antipsychotic medication used to treat the symptoms of schizophrenia and manic or mixed (manic and depressive) episodes of bipolar I disorder. Aripiprazole is in tablet and liquid form. An injectable form is used in the treatment of symptoms of agitation in schizophrenia and manic or mixed episodes of bipolar I disorder.’

The booklet also introduces Clozapine on the first page of information on medication, although as discussed earlier, it is reserved for particular circumstances of severe ‘treatment’ resistance. By comparison, the book comprises psychological and social interventions, cognitive behavioural therapy, illness management skills, integrated treatment for co-occurring substance abuse, rehabilitation, and family education and self-help groups into two pages.

The second publication that Angela used, was ‘Discover the Road Ahead: Support and Guidance for Everyone Affected by Schizophrenia’ (Elgie et al. 2004). The team expected the key nurse on the homecare team to give a copy of the book to each family where it made a diagnosis of ‘schizophrenia’. Published by the Bristol-Myers Squibb Company and Otsuka Pharmaceuticals
Europe, the government minister with responsibility for mental health launched the book in Ireland in 2006. The book also received an endorsement from Schizophrenia Ireland. As its primary explanation of 'schizophrenia', the book states dopamine 'stands accused' as the cause of 'schizophrenia'. Using this as its rationale, it places medication at the forefront of treatment. Aisling, did not rate the publication very highly stating it:

"...does not have much information in it, like if you have a brain and you read it, then you will realise that it is very not deep or anything, it does not go into much detail, some people don't think for themselves, and they just accept the medication, but you know I am not like that"

A key strategy used by pharmaceutical companies is that of raising disease awareness, campaigns and marketing strategies set about trying to educate the marketplace, to prepare the ground for treatment. Perehudoff & Alves (2011) consider that pharmaceutical companies present 'educational materials' formulated as 'disease information', as a way to stimulate people to identify unmet needs by raising awareness of issues 'related' to the diagnosis. Invariably, promoting their products as solutions to these problems, this increases reliance on medication as the solution. In some markets, pharmaceutical companies orchestrate this using their support of scientific societies, patient advocacy groups and even governments.

The content of these publications troubled me. Relman (2008) argues that although the pharmaceutical industry likes to call the provision of literature 'education', it is not, it is 'marketing'. Over the past thirty years, as identified in court cases, the interests of psychiatry and the pharmaceutical industry are intertwined (Whitaker 2010). However if a campaign does not breach advertising standards, 'education' is relatively unrestricted. Relman (2008) believes that psychiatry's relationship with the pharmaceutical industry has limited the discourse on mental health to one of illness, biomedical interpretation and pharmaceutical solution. He identifies the primary interest of the pharmaceutical company is profit; its responsibility is not to the end user but to its corporate shareholders. Both Kutchins & Kirk (1999) and Whitaker (2010), suggest that pharmaceutical companies manipulation of discourses were promulgated largely with the assistance of psychiatrists. When the American Psychiatric Association struggled with its profile in the 1970s and 1980s, the relationship between corporate pharmaceutical companies and psychiatry grew, with the development of media training and campaigns to extol the virtues of psychiatry and the use of medication that psychiatry controlled access to, by virtue of prescription.

The publications used by the team constituted a form of 'institutional reflexivity', which Giddens sees as the way modernity increases its intrusion into aspects of social life and people's interaction with nature, constantly forcing people to revise their engagement (Giddens 1991:2). Clinicians encounter these 'institutional reflective' processes when they use manuals,

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53 The Otsuka Pharmaceutical Company in Japan developed the well-known antipsychotic medication Abilify or Aripiprazole, which it markets jointly with Bristol-Myers Squibb Pharmaceuticals.

54 'Schizophrenia Ireland' was a voluntary organisation founded in 1975 by relatives of people diagnosed with 'schizophrenia. Its objective was to promote awareness of the issues surrounding 'schizophrenia'. The organisation underwent a name change to 'Shine' on 1st February 2009.
guidelines, assessment tools, self-help guides, pamphlets, research and academic texts such as those described. Their use influences both service users and service providers, as they act as an ‘aide memoir’ reminding people what they should prioritise. Within the team, they supposedly determine how the members should act, the information they should communicate, what they should look for and how they should feel. This type of information not only directed staff actions but was also influential in extending the discourses they contained, increasing the perception that the information they contained was without question. The consequence of these processes is that ultimately they fashion the person’s identity of ‘self; they influence the way a person given the diagnosis thinks about him/herself and coaches the professionals how to think of themselves as a practitioners.

The dilemma I faced was complex. The content and structure ‘signified’ in these publications could convince a person that the service’s principal intervention, the long-term use of psychotropic medication to control symptoms was the only alternative. In the discourse, nursing care becomes dominated by medication compliance. The emphasis is placed on ‘symptom’ removal and trying to ensure people’s behaviours does not draw them to the attention of the wider public. The conversations that nurses have, come to reflect this. I remained torn as to whether to use the publications despite my objections to their content. The service had an expectation that I would use the literature; yet I felt the literature unbalanced and presenting information engineered to strengthen the discourse of corporate pharmaceutical companies. My dilemma was should I provide information that I considered an unbalanced and biased interpretation of the diagnosis that conformed to the service’s way of working or provide no information at all. Not using the information created another layer of dissonance. Although, I could justify its use, arguing that in a service with limited resources, the ‘free’ book offered knowledge that conformed to many of the professionals’ beliefs about the diagnosis. Was it not better to work with a shared interpretation of the ‘schizophrenia’ diagnosis even when doing this caused ‘personal’ dissonance? With this in mind, I also recognised my ‘impermanence’ in the service and people’s lives; I knew I would leave; my replacement would offer another perspective on ‘schizophrenia’, underpinned by values unknown. I did not voice my protest, but I did not distribute the book.

Vicarious Dissonance: The ‘Broken Brain’

During the fieldwork, some of the greatest experiences of dissonance I had surrounded other team members beliefs about ‘schizophrenia’. Individually, members of the multidisciplinary team held differing interpretations of the diagnosis. A key event in the recognition of dissonance within the study came in Week 20 of the fieldwork. It surrounded the care of Andrezej, the 19 year-old Polish Roma emigrant given a diagnosis of paranoid ‘schizophrenia’ in his native Poland, and centres upon a family meeting with Andrezej and his parents.

This meeting was my first family conference as a full member of the team. As family plays a major part in Roma culture (Morrison Puckett 2005), the team asked for a family meeting in the hope that pressure from Andrezej’s parents might improve his engagement with his plan of care. The meeting took place on a Thursday afternoon; Andrezej, his father Bo and mother Luludja arrived on time. The consultant psychiatrist, the clinical nurse manager of the Day

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55 The Romani name ‘Bo’ translates as ‘settler’ or ‘coloniser’ while ‘Luludja’ translates as ‘flower of life’.
Hospital, Claire; one of my CNS colleagues Regina, and me, as Andrezej's key nurse, represented
the team at the meeting. We convened five minutes before the meeting to discuss how as a
team, we would approach the meeting. The consultant psychiatrist decided he would take the
lead. He would then ask each member of the team to recount his or her experience of working
with Andrezej. He emphasised that, as a team we should:

'...present a united front'

The 'fateful moment'\textsuperscript{56} for me came in a statement made by the consultant as he explained the
diagnosis of 'schizophrenia' to Andrezej and his parents when he stated:

'...your son has brain damage...he has schizophrenia'

Field note: Thursday, Week 20

I could not believe I heard this used as an explanation, did I mishear it? I noted my reaction to
the statement in my field notes:

'I sat and stared, I said nothing. I was in shock. I looked at my colleagues nobody else
appeared to react. The statement appeared insignificant to all but me. This explanation
of schizophrenia does not fit with my understanding of the diagnosis. What would the
consequence of the statement be? What would such a statement mean to Andrezej?
Andrezej had an irreparable functional disorder of his brain, an insult which neither the
team, nor his family were capable of reversing. There was to be no hope of repairing
this 'damage'. The only course of intervention would be to control the effect of the
'damaged' brain.'

The statement about 'brain damage' conflicted starkly with my own beliefs and values. The
common interpretation of the term 'brain damage' brings connotations of irreparable damage
and hopelessness, and this interpretation of schizophrenia was incongruous with my beliefs
about the diagnosis. A raft of emotions flooded my consciousness. I was angry with the use of
the explanation; I was embarrassed at the 'labelling' of Andrezej. Haghighat (2008) identifies
that when people use a prevailing discourse of 'schizophrenia' not only does this make changes
in the outside world, but it also changes peoples' inner world. Accordingly, connotations can
have ramifications for people and families of a catastrophic nature and fundamentally shape
their identity. The episode also had ramifications for me. Throughout my engagement with
Andrezej, I felt as though I tried to overturn this belief, trying to prove to myself that his brain
was not broken.

One of the ways people cope with dissonance is by 'justifying' to themselves that there was a
good reason why something happened the way it did. This appeared to be the case to me as I
wondered whether the psychiatrist really meant to tell the family that their son was 'brain
damaged'. Three days prior to the meeting, I discussed with the consultant psychiatrist whether
we should use a translator. On the previous occasion when the team tried to meet with

\textsuperscript{56} Giddens (1991) explains that people can be confronted by 'fateful moments'; crossroads when they
know that decisions must be made that require them to embark on a new path, to make a decision that
will be very difficult or cannot be reversed.
Andrezej’s father, Bo, it booked a Polish translator; Bo did not turn up. Translators were expensive and resources were now an issue in the sector. The consultant psychiatrist thought it was not necessary, he felt both Andrezej and Bo had sufficient English to comprehend, so on this occasion it was decided we would not use a translator. Gerish et al (2004) identify that where consultations occur without translators, poor communication results which often creates a lack of understanding of problems and treatment. They also consider that it is more likely to lead to detrimental effects for health. The consultant reasoned that Andrezej and Bo would be able to explain to Luludja (his mother), his exact words:

‘...we will be able to get our meaning across’

I reasoned with myself why the ‘broken brain’ explanation was given. Perhaps the psychiatrist used the explanation in an attempt to break the language barrier. I never heard the ‘broken brain’ analogy used again. In an attempt to provide an explanation of ‘schizophrenia’, the consultant tried to use in the simplest form of language what he perceived the problem to be. He attempted to provide the most basic understanding using his fundamental interpretation of the diagnosis. I also reflected that there might be another reason why I did not challenge the ‘brain damaged’ explanation. The amount of literature attributing a biochemical or genetic basis to ‘schizophrenia’ is voluminous, and at some point it might not be unreasonable that evidence may be found to substantiate the claims.57

Although few people use the language of a ‘damaged’ or ‘broken brain’ in practice when dealing with service users or families, many people support that interpretation of ‘schizophrenia’. When placed in the context of the work of the renowned American psychiatrist, researcher and author on the medical diagnosis of ‘schizophrenia’, Nancy Andreasen, people might consider the explanation a reasonable interpretation. Author of the Trilogy, ‘The Broken Brain’ (1984), ‘Brave New Brain’ (2001) and ‘The Creating Brain’ (2005), Andreasen is also known for formulating the Scales for the Assessment of Positive and Negative Symptoms of ‘schizophrenia’ (SAPS & SANS). In the ‘Brave New Brain’, Andreasen (2001) ascribes the causation of ‘schizophrenia’ to neurodevelopmental abnormalities ‘when the brain does its final ‘growing up’ during the late teens and early twenties’ (p.203). In support of this argument, she hypothesises58 that although not ‘...doomed from the womb’ (p.201) as in ‘Trisomy 21’ or ‘Foetal Alcohol Syndrome’, she proposes that a number of factors could possibly account for these neurodevelopmental anomalies such as genetics, in utero infection and malnutrition. Andreasen’s perspective is also ascribed to by the noted American psychiatrist and ‘schizophrenia’ specialist E. Fuller Torrey (2011), who states ‘...the answer, which has become overwhelmingly clear in the past 2 decades, is that schizophrenia is a disease of the brain. It exhibits abnormalities of the structure and function of that organ (p.466)’.

57 Boyle (2002) and Hornstein (2009) both discuss the manner in which the discourses of medicine, science and biology have come to dominate society’s perception of schizophrenia and how these discourses have come to perpetuate an expectation that an answer to schizophrenia’s because is just one small breakthrough away.

58 Andreasen talks about ectopic grey matter development in neuro-imaging studies which do not migrate to their proper locations.
The ‘united front’ advice given pre-meeting caused great discomfort after the use of the ‘brain damaged’ explanation. As a member of the team and party to the meeting, I would also vicariously be seen to subscribe to the explanation by association. I wondered as to the impact of confronting Andrezej and his family with the prospect of brain damage. The ‘brain damaged’ statement challenged me; this was not who I saw Andrezej to be. I felt in his analysis the consultant did not represent my belief system, yet following the ‘united front’ discussion which preceded the meeting I would not speak out. I was sensitised to such descriptions. It did not represent my understanding of Andrezej’s diagnosis of ‘schizophrenia’. I realised that my understanding of ‘schizophrenia’ and the consultant’s explanation differed greatly and in an attempt to simplify the medical diagnosis, he framed it using an interpretation of the diagnosis that I could not accept.

In clinical environments, there are ‘no go zones’, with informal pressure used to control information. In the encouragement to present a ‘...unified response’; I was effectively encouraged ‘...not to rock the boat’. It created a ‘ taboo’\(^59\). In social systems ‘taboo’ subjects are spoken in ‘veiled’ whispers, couched in fear and embarrassment. Recalling the consultant’s response I described earlier, when Regina questioned prescribing practices, in Andrezej’s case, I decided to remain ‘silent’. However the consequences of ‘silence’ and its role in society and organisations can prove problematic. Zerubavel’s (2006) analysis of ‘silence’ identifies that in Hebrew, ‘silence’ and ‘paralysis’ have a common linguistic root. Trauma is only one factor in silence. There is equally a role for embarrassment, pain, fear and shame. He considers that people are socialised into responding with ‘silence’ and learning to ignore; he considers these responses always involve dissonance (Zerubavel 2006). He identifies that part of a professional’s socialisation in power structures is sensory shut-off; tacitly ‘ignoring’ specific phenomena. People learn what can be ‘ignored’ at an early stage in life. It involves cognitive orientation; people observe what they wish to observe. Thus, denial is the product. Their decisions on when to act emerging as socially constructed phenomena, developed through watching others.

People are often intimidated into remaining silent and silence breakers are generally resented because they disrupt the “cognitive tranquillity” (Zerubavel 2006:74). When the episode is analysed within the domain psychology theory, the factors of conformity and obedience offer explanations for people's decisions to remain silent and acquiesce to authority.

Brehm, Kassin & Fein (1999:213) define conformity as “the tendency to change our perceptions, opinions, or behaviour in ways that are consistent with group norms”. Stemming from the work of Sherif (1936), in conformity when people who initially hold disparate opinions are placed in the presence of peers, conformity emerges within the group. Asch’s (1951) seminal study demonstrated that when individuals were placed in a group of peers, where an obviously incorrect decision was made, in 37% of the situations the person conformed with the group’s actions. A number of factors can be seen to influence conformity. A significant factor is the concept of normative influence; participants will generally conform, where there is a fear of negative social consequences. A second factor is that of informational influence; individuals

\(^{59}\) A taboo, is a breach in society's expectation; a person is deemed a 'social deviant' if they break a 'taboo'.
conform because they believe others' judgements are correct. Fein, Goethals & Kassin (1998) identify that the presence of an ally also influences conformity.

The second factor worthy of consideration in this domain is the concept of obedience. Brehm, Kassin & Fein (1999:232) regard obedience as the "behaviour change produced by the commands of authority". The power of an authority figure and their presence in the environment has direct influence on the degree of obedience exerted upon others in their sphere of influence. The relationship between medicine and nursing in many circles is still considered as one of master and servant. Enshrined in the Mental Health Act (2001), the consultant psychiatrist has ultimate decision-making power in the treatment of people with mental health problems. In such considerations, a relationship expecting obedience can be seen.

In Andrezej's situation, the other team member's silence became reinforcement for not talking, they in essence became 'allies' in the process of conformity. I did not wish to transgress or break the 'norm'. The longer people remained 'silent', the more difficult it became for me to challenge. The more people did 'not question', the more I doubted my perception of the situation. The 'silent bystanders' became enablers to the silence. I became subject to peer group pressure, becoming more fearful of being challenging.

Considering the power relationship of the consultant psychiatrist, I felt I needed to learn from Regina's case earlier, "knowing what to know", I responded with 'self-censorship', I became 'obedient' adhering to the direction of 'maintaining a united front'. I chose not raise the issue of Andrezej, I believed that if I did my research would not progress, however I knew that if I was not undertaking the research I still would not have raised the question at the time (normative influence).

Reducing dissonance: Creating a personalised interpretation of 'schizophrenia'

In the self-concept model of dissonance, Aronson (1968) identifies the role of personal standards in dissonance. He forecast that people with high self-esteem experience more frequent and powerful dissonance from high internal standards and suggests where a standard is breached dissonance arises. The discussion on Andrezej above highlights an important aspect on how I sought to reduce the dissonance that I experienced from the consultant's 'broken brain' description used with Andrezej's family. Here, the decision became one of the personal standards I selected.

"...one cannot practice without an implicit model of the people on whom one is practicing"

Lipsky (2010:152)

I cited Lipsky's work about 'street level bureaucracy' and its applicability to psychiatric nurses in the methodology section. Here I want to draw attention to a core element of Lipsky's theory of street-level bureaucracy (2010), namely that street-level bureaucrats construct and operate from an 'implicit model' of the person they interact with. When working with people with a diagnosis of 'schizophrenia', the psychiatric nurse's interpretation of the medical diagnosis.
becomes an integral component of the model they construct. This model underpins the psychiatric nurse’s relationship with the person and the care he/she provides. The model underpins the psychiatric nurse’s understanding of the condition in day to day practice, and in a way provides the psychiatric nurse with a ‘protective cocoon’ from the problems that an ambiguity in theories cause (Giddens 1984). The individualised model reduces the potential for dissonance, insuring ‘ontological security’ (Giddens 1984) for the practitioner, so as to present ‘rationales’ for his/her action. For the practitioner, the model is dynamic, constructed from the psychiatric nurse’s own beliefs, values, experiences and education. What follows here is a description of the model constructed around Andrezej.

Building my internal model of Andrezej’s ‘schizophrenia’, I did not see him as ‘brain damaged’, and struggled with that interpretation. I did not want to accept this notion. In the varied interpretations of schizophrenia causation, I dissociated myself from the sentiments expressed in the meeting. In my role in Andrezej’s care, the standard by which I viewed ‘schizophrenia’ became my free and personal choice. I built my interpretation, one that I used to engage with Andrezej.

The construction of the personalised interpretation of ‘schizophrenia’ that a practitioner applies to an individual person can be complex and multifaceted. For the most part the factors explain the phenomena psychiatrists consider when they formulate the diagnosis of schizophrenia. The following interpretation details the factors, which went into the formulation of Andrezej’s experiences.

The Andrezej I encountered was an emigrant, part of a family trying to build a life in a new community. Andrezej did not appear deluded. Cannabis use played a significant part in exacerbating his voice hearing experiences (Andréasson et al. 1987, Arseneault et al. 2002). Andrezej was a voice hearer who could not cope with the experience. He feared the voices he heard; they affected his sleeping pattern. This problem brought him to the service. I never saw evidence of the symptoms of social withdrawal or inactivity, negative symptoms, commonly associated with both acute and enduring presentations of ‘schizophrenia’ (Gelder et al. 2005). I saw him regularly in company, usually at the centre of the group. He functioned in his peer group; he had a girlfriend. As a service user, Andrezej would present when he felt it was necessary. The service had difficulty coping with this type of relationship, preferring people to engage at set times and to keep appointments. When people missed appointments staff regarded it as resources wasted and a depriving of their time, from which other people using the service could benefit. However, I felt that I was an imposition on Andrezej; that ultimately my presence was not really wanted.

In addition to the role of cannabis in exacerbating Andrezej’s psychosis, I used a number of theories to explain his experiences. Migration and the attendant cultural and social adjustments can have a profound effect on the mental health of a person (Bhugra & Jones 2001, Sharpley et al. 2001), with increased risk for emotional disturbance exacerbated by the loss of family support networks. Often in such situations children have heightened vulnerabilities to mental health problems, with parents overwhelmed by their own situations struggling to cope (Pumariéga et al. 2005). The Stress-Vulnerability-Cognitive Model of Psychosis (Kuipers et al. 2006) identifies the role of life stressors in increasing the vulnerability of people to psychosis-
type experiences. There is also an extensive body of literature that documents the role of trauma and abuse in psychosis and voice hearing experiences (Mueser et al. 2001, Kilcommons & Morrison 2005, Read et al. 2005, Romme & Escher 2006). The uprooting of Andrezej’s family and settlement into a new society presented severe challenges for all concerned.

I felt Andrezej’s ethnicity might also increase his vulnerability to psychosis type experiences. There are consistent reports of high rates of psychotic disorder and psychosis-like symptoms amongst minority ethnic groups (Harrison et al. 1997, Sharpley et al. 2001, Cantor-Graae et al. 2003, Kirkbride et al. 2006). The fourth National Survey of Ethnic Minorities in the UK (Johns et al. 2002), identifies hallucinatory experiences amongst the Caribbean community at a 2.5 times higher incidence than the general population. In addition to the high levels of psychosis identified in minority ethnic communities, there is also evidence of higher levels of psychosis among emigrant populations. Selten & Sijben (1994) report that the rates for emigrants from Dutch territories in the Caribbean far exceed those of the native-born population. Andrezej, at points in his life, lived the experience of a person from an ethnic minority and an immigrant in a new community. He received his initial diagnosis of ‘schizophrenia’ whilst in Poland, where the Roma community represent a small ethnic minority, comprising less than 1% of the population with numbers estimated at 30,000. Morrison Puckett (2005) provides an analysis of the Polish Roma community and their interactions with social services. She describes the community’s roots beginning as nomads travelling to Eastern Europe from Northwest India 600 years ago. The group were targets of the Nazi Holocaust and suffered as economic victims under both the communist regime and the resurgent capitalist economy in Poland. As a group, they were subject to prejudice and resentment within Polish society and sufficient protection was not given to their rights. Historically members of the Roma community remain separate from non-Roma communities and the group has never been politically active, spread as they are across a number of countries, with no definitive homeland to claim. Characteristically, the group identify with other ethnic groupings within society, in order to gain privileges that such association may bring. Many travel to seek employment or to escape violence. The group depend heavily on itinerant trade and crafts, for their economic survival. As a group, the Roma generally do not access state services. The community relies on family networks in times of trouble, with the predominant sense of thinking that they “take care of their problems in their own community” (Morrison Puckett 2005:628). Forced to the margins of society, accounts of their plight parallel those recorded about and by the Irish traveller community (Mac Laughlin 1999). The Roma in Poland are subject to widespread discrimination with reports of social exclusion from public places such as public houses, restaurants and hotel accommodation. The group frequently occupy low socioeconomic and educational statuses within society, caught in a cycle of unemployment, poverty and low educational attainment, considered as either unable or unwilling to keep jobs for long periods. Morrison Puckett (2005) accords perceptions in society that members of the community do not have the skill set for life in the modern world or the modern economy. The Roma tend to resist formal education and show a very low rate of educational attainment within schooling systems. Their attendance rates are low. The explanation of this is in part due to the group’s ability to survive outside the formal educational system, as their traditional roles within the economy have not required it. In addition, the educational curriculum offered to Roma children is at odds with their traditional family values, as it removes the children from a productive economic role within the family network. A second
aspect seen to discourage the community from entering the education system is the manner in which mainstream education places Roma children in the 'disabled' category, with children frequently labelled with dyslexia. The education system in Ireland placed Andrzej in this category.

Littlewood and Lipsedge (1997) identify that when a psychiatrist makes a diagnosis of 'schizophrenia', they can often show a lack of understanding of a service user's ethnic background, which can lead to overriding the presence or absence of 'key symptoms'. They consider that people receive a diagnosis of 'schizophrenia' because there is a lack of sympathetic knowledge regarding the cultural background of the person, who can appear unintelligible. They believe misdiagnosis can result, with people subjected to 'unnecessary long-term medication, the stigma of mental illness and a self-perception as an invalid' (Littlewood & Lipsedge 1997:105). I struggled with the label placed on Andrzej, as outside of his voice hearing experiences he exhibited none of the other diagnostic signs.

I believed that Andrzej could learn about his experiences; that he could learn to live with and cope with voice hearing as an experience. I felt there was a role for medication in the short term in helping Andrzej cope with his experiences, but that medication was not the only approach, which could benefit him. I believed that people should have input into decisions on the most appropriate level of medication. I reasoned that if we could create an understanding of his experiences that he might be able to accept and cope with hearing voices, what was needed was time and engagement. This was the model, which I formulated in relation to Andrzej, and I endeavoured to use it as the basis for our relationship. I did find some solace that I was not alone in struggling with such interpretations, neither was I alone in building my own model, as reflected by Colm, a staff nurse. He explained:

"You see I have a very different understanding of schizophrenia now than I had before. I don't subscribe to many of the medical explanations. I suppose it's because I have been influenced by the likes of Phil Barker60, I just don't know anymore, usually when I try to explain it, I talk about the person, I try not to talk about the diagnosis at all"

Field note: Wednesday, Week 26

Dissonance in attempting to manage care effectively

In 'street-level bureaucracies' the dilemma between meeting the needs of the individual and the finite nature of resources poses great difficulty for professionals. This is a phenomenon which particularly challenges nurses when working with the diagnosis of 'schizophrenia', as the 'cost' of care in 'schizophrenia' generates inconsistencies which nurses struggle to come to terms with, feeling frustrated by people's responses to treatment. These responses present

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60 Phil Barker's philosophy is best espoused in his Tidal Model (Barker 2000) for the practice of mental health recovery. Its focus in mental health care rests in the world of ordinary life. It sees people's lives as residing in an 'ocean of experience'. A crisis of mental health, which might arise, may potentially overwhelm them, leaving them 'drowning' in the ocean. Barker believes that mental health care's 'aim' should be to 'return people to their 'ocean of experience', so that they might continue with their 'life voyage' of their lives.
nurses with challenges in the priorities they give to particular aspects of care and the amount of resources they should ‘invest’ in each individual person.

Periodically the members of the team discussed these dilemmas both formally and informally. The discussions usually revolved around a number of issues: how the team’s resources should be deployed, whether treatments were effective, people’s commitment to treatment and compliance with medication and the extent of risk. Meetings also considered whether the team should transfer care to another area, to what extent people should be permitted to dictate the choice of treatment or ultimately whether it was necessary to treat people as a non-voluntary patients in the Meadowfield Unit. During lunchtime on occasion, nurses without the presence of other team members, would allow personal feelings an ‘airing’. The following account of Friday lunchtime, illustrates how nurses’ dilemmas in care arise. It centres on the relationship of Claire, then working in the Day Hospital and Aisling, a young woman given a diagnosis of schizophrenia. The episode centres on the frustration and dissonance that work in the diagnosis of schizophrenia can cause, in services trying to operate within the bounds of finite resources. It shows how at times the amount of resources a team spends can be perceived as returning little improvement.

There was a small group present for the discussion, only five nurses. Aisling arrived at the health centre for her dose of ‘clozapine’, which at the time she received daily under the supervision of the nursing staff. She was to attend for 10am; it was now 1.30pm. Staff closed the health centre door for lunch. As was often the case, a swipe card was passed through the window to allow Aisling enter. Claire left lunch, administered the medication, and returned to finish lunch. Frustrated, she expressed her views on the amount of resources spent on Aisling, which it appeared she believed was more than any other person in the service. She felt staff over engaged with Aisling and suggested the amount of resources in use was counterproductive, she commented:

"Would it be better if we pulled back and not waste time?"

Field Note: Friday, Week 24

After completing a course in management, Claire appeared sensitive to these issues and was conscious of the finite capacity of resources available. As a measure of effectiveness, Claire identified the continued presence of symptoms and Aisling’s reliance on the team. Claire questioned the amount of time spent because of Aisling’s ‘non-adherence’ with Clozapine. Claire commented that there were now two or three weeks supply of Aisling’s Clozapine in the drug press that she had not taken since it was introduced three months earlier. They suspected there was more in her apartment. Those present acknowledged that they did not believe that Aisling took the medication as prescribed either. Justifying her belief, Claire maintained the cost to the health service of treating Aisling with Clozapine was 60,000 EUR\(^6\) per annum, a figure ‘revealed’ to her by one of the manufacturer’s sales representatives and this figure:

\(^6\) The most extensive estimate of the direct cost of care for a person with a medical diagnosis of ‘schizophrenia’ in Ireland was conducted by Behan, Kennelly and O’Callaghan (2008). In 2008, they estimated the total direct cost of care for schizophrenia was 117,459,000 EUR, an average of 11599.74 EUR per person. They estimated medication costs comprised 1,166.28 EUR of that total. Their overall estimate of the cost of diagnosis to the nation, including indirect costs accounted for by informal care,
...did not include the staff costs”.

Field Note: Week 24

I attempted to verify Claire’s claims with the manufacturers Novartis; the Clozapine Patient Monitoring Service, and ultimately the pharmacist at Rathmullen Hospital who dispensed to Glenvilly. The pharmacist was surprised at Claire’s estimate. The actual cost of Clozapine to the clinical site at the time of the study was 2.74 EUR per Clozapine 100mg tablet. She estimated Aisling’s medication cost 4000.40 EUR per annum. However, the point is that Claire believed that Aisling’s care was a waste of resources, considering Aisling would be much better off with a form of treatment that could be controlled by the team, thus ensuring better compliance.

For nurses a major impetus for their involvement in care comes from meeting the needs of those in distress. Dissonance arises when the capacity to meet those needs is compromised by external sources limiting their ability to do this. Claire’s estimations of cost can be considered in the context of dissonance reduction. In order to be able to divest herself of the responsibility of care and withdraw from a person whose needs she clearly identified, Claire required a ‘cognition’ to justify her response. This she found in the ‘justification’ of the cost of Aisling’s care.62

In truth, what was Aisling’s service use that everybody considered so sizeable? In the day hospital, outside of the period when clozapine was initially introduced, Aisling may have had a 5-minute daily interaction with the nurse who supervised the administration of her medication and perhaps an additional 5 minutes taken to document the resultant interaction. She might stay for a short while and interact with some acquaintances but she did not get involved in any of the other activities. On some days, a nurse might need to phone Aisling to remind her that she should call for her medication. Then there was a ten-minute interaction for her blood test every two weeks to check for possible blood dyscrasias; however, a nurse travelled from Rathmullen to run the clinic for the clients on Clozapine.

Over a period of three months, between Week 35 and Week 48 of my clinical involvement, once a week Aisling met with the clinical psychologist for a 50-minute session where they explored the relationship with her voices and the strange thoughts, which preoccupied her. During this time, they devised an intensive programme, allowing Aisling to examine her experiences of unemployment and absence from work, the cost of early mortality, social welfare administration, prison service involvement and homeless service provisions to the group, was calculated to be 460,000,000 EUR, an average of 45,427.61 EUR per person, still short of Claire’s estimate.

62 Rössler et al. (2005) believe that the economics of schizophrenia only became an issue for psychiatry with the advent of cost containment in health care. According to the World Health Organisation (2001), the fact that ‘schizophrenia’ causes a high degree of disability makes it one of the most burdensome and costly illnesses for a state. Rössler et al. (2005) identify that whilst current interventions allay approximately 13% of the burden associated with ‘schizophrenia’, ‘optimal treatment’ could reduce this burden by 22%. Kavanagh et al. (1995) identify four ‘resource keys’ as fundamental to successful ‘schizophrenia’ care, adequacy, distribution, timeliness and coordination. They consider that helping people cope with the phenomena of schizophrenia currently relies upon three forms of intervention. Firstly, pharmacological intervention should be used to alleviate ‘symptoms’ and for relapse prevention. Secondly, psychosocial intervention designed to improve the person’s and family coping with a view to preventing relapse. Thirdly, social reintegration of people into community utilising rehabilitation programmes focusing on restoring lost occupational functioning.
public places and her reactions to her strange thoughts they generated. The programme entailed a time commitment of two additional hours for one member of staff per week, a role shared jointly by Angela, Claire and Will, the occupational therapist on a rotating basis.63

Yet Aisling’s was a name on the day hospital board, a space occupied that prevented another name being entered. Its two staff at its capacity could handle a maximum of 12 people daily. Shared with the neighbouring team, Glenvilly had an allocation of six places. Demand for places was high and days and staff rationed places depending on the severity of the presentation, with clients attending on average for two to three days per week. Most people did not attend for more than six weeks. On a Friday evening, the registrar might review Aisling in the Day Hospital, an interview that usually lasted 10 minutes, however this usually only happened every second or third week for the review of her blood tests and an assessment of her mental state.

A similar case might be made for the level of burden perceived by the homecare team nurses. Aisling was not on their books during the regular working week. Only during times when compliance was questioned did the team do weekend calls to supervise medication. It was a visit, which might last ten to fifteen minutes and her apartment was a five-minute drive from the health centre. On some occasions, Aisling might even save the nurses the driving time, calling to the centre herself or meeting the nurse on call for coffee in the local coffee shop. In a similar vein, they might spend 5 minutes documenting a one-line or two-line record of events.

Aisling drifted on and off the books of the day hospital, homecare team and CNS team over the period of the year, alternating between the three. She would drop by the day hospital unannounced. Occasionally, she would leave her bicycle under the stairs in the health centre for security for extended periods, giving the appearance she was there, when in fact she was not. It appeared as though she occupied a space continuously, but in truth was only there for short periods. This perhaps fuelled the dissonance nurses in the day hospital experienced leading them to believe the burden was greater than it truly was; the timespan of the case a reminder of the resistant nature of her psychosis and their inability to succeed in improving the quality of her life.

In conclusion, this chapter has detailed the difficulties that the language of schizophrenia and the economics of its management present. It shows how professional dissonance emerges from

63 Lipsky (2010) identifies a number of ways street level bureaucrats ration services, they act by controlling access, both formally and informally. Rationing occurs at the point of contact with staff deciding who gets in and by refusing to take certain types of cases. Within the service staff engaged in a number of practices which controlled access:

1. Timing of calls, knowing that when you contact individuals they will not be available and subsequently documenting the fact that attempts were made, provide evidence of not engaging, reinforcing the case for discharge
2. Forcing people to contact the secretary as a gatekeeper to access
3. Using the answering machine to pick up clients messages
4. Selectively providing or withholding information
5. Not exploring different avenues of treatments and working to a pharmacology agenda reduces the demand for other components on the service and controls the type of service, which will be given to individuals
6. Making individuals wait or not giving an immediate response

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the ambiguity and dichotomy surrounding the diagnosis. The chapter reveals that the language of schizophrenia creates uncertainty, confusion and misunderstandings. The connotations of schizophrenia traumatise individuals and place staff in ethical dilemmas, shrouded in the fear of using the wrong words. The chapter also illustrates the dissonance of trying to run services to a cost. This forces nurses to prioritise their beliefs in professional ideals at the expense of questioning the 'unconditional' value of the person.

In their attempts to reconcile dissonance, the chapter shows how practitioners formulate their own interpretations of the diagnosis and what they believe the preferred treatment should be. It also reveals their beliefs as to what objectives the person diagnosed should achieve. Ultimately, it shows the effects an individual nurse's interventions can have on peoples' lives, an aspect I wish to follow up on in the following chapter where I will continue the analysis of the areas that cause dissonance and the effects they have on the lives of people.
Chapter 7: Dissonance arising from patterns of engagement

Introduction

A key element of the nurses' role working with people given a diagnosis of 'schizophrenia' is 'surveillance', a role that created significant difficulties for me as a nurse in practice. Essential to 'surveillance' is nurses' engagement with people, and this second chapter of analysis explores the dissonance that arises in surveillance. I have again drawn upon the work of Michel Foucault (1991) in framing the analysis, and used his concepts of 'correct training' and 'creating docile bodies' as a way to explain how psychiatry and, following in its wake, psychiatric nurses like me attempt to control those whom we perceive to be at 'risk'. The chapter also explores the responses of 'dependence' and 'ambivalence' by people with a diagnosis of schizophrenia to my attempts to engage. It considers dissonance arising from how I and other nurses exercise control, through using 'tools' that reinforce 'schizophrenia' and 'punishment'. The analysis then focuses on our involvement in medication use and 'coercive' practices, concluding with an exploration of one incident where I failed to sustain engagement with a person.

'Surveillance'

Foucault (1991:136) proposed that within society the body of a person becomes an object that can be manipulated in the pursuit of creating a 'docile body', a body that can be 'subjected, used' and in the case of psychiatry 'transformed and improved'. For psychiatry to function efficiently it requires a 'docile body'. To create a 'docile body', psychiatry exercises its 'disciplinary power' using a process of 'correct training'. Foucault describes three strategies that are used as means by which a 'correct training' or the establishment of disciplinary control can be achieved: 'hierarchical observation', 'normalising judgment' and the 'examination'.

'Correct Training' involves the imposition of constraint, which is manifest in the tools of surveillance, and control, for which psychiatric nurses are 'essential' agents. When it comes to working with people with a diagnosis of schizophrenia, society empowers psychiatry to implement a social control role. This mandate can often conflict with fundamental elements of a caring profession's ethos, such as those of promoting autonomy and independence, to which nursing aspires as promoting recovery. Here dissonance may arise for the nurse between promoting autonomy and the imposition of constraints, which their actions may require. However, in attempting to reduce the dissonance, the reduction strategies nurses use frequently only serve to generate dissonance that is more complex.

One of the highest levels of dissonance I experienced over the course of the fieldwork related to my role in 'surveillance'. In their 'surveillance' roles, I noted nurses tried to educate people

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64 Hierarchical Observation: A process used to make a person become 'subject'; becoming their own guardian, never sure that they are not being observed their behaviour being circumspect mimicking what is desired of them. The ultimate incarnation of this, Foucault perceived as Bentham's 'Panopticon', a prison construction where the individual is never sure when she/he was being observed.

Normalising Judgment: A disciplinary mechanism of using small penalties coercively to bring about changes in the person's pattern of behaviour.

Examination: A ritualised disciplinary technique used to qualify and classify a person, to make them seen, documented and categorised as case.
diagnosed with 'schizophrenia' in the ways that the service needed them to act. The 'correct training' was important to the CNS, as it enabled them to function with the large number of people assigned to their care. Angela brought home the lesson to me following my interactions with a service user in Week 35 of the fieldwork. The service user did not attend the clinic for his depot injection on the scheduled day. He phoned to apologise for missing the appointment and I played down the oversight. I offered to give the injection the following day and gave the person a choice in the time he would call. On putting the phone down, Angela challenged me:

'What did you do that for, don't you know you will never get him into the routine like that…'

The clinical nurse specialists struggled to accommodate people who did not engage 'properly'; they used the term 'messing around' to describe this behaviour. If a person missed an appointment, a simple way they used to establish control within the relationship was to force him/her to attend the health centre for appointments rather than making appointments at their home. Lipsky (2010) identifies this as a way that street-level bureaucrats ration services. This ensured time was not 'wasted' on a second occasion. The 'lesson' for the person or 'training' came through imposing a penalty; making the person call to the centre rather than receive a visit in their own home; a 'cost' in time and travel outlay.

People given a diagnosis of 'schizophrenia' responded in different ways to surveillance and the presence of a psychiatric nurse in their life. Some people rejected the need for the nurse's presence but tolerated it, prepared to engage to some extent. Others became reliant on the nurses with whom they worked. I found these two patterns of engagement fell broadly across gender lines. Women were more likely to develop strong relationships with their nurses that led to their seeking frequent contact and occasionally, they crossed 'boundaries' in the service. Men were more likely to reject the presence of the service and be less accepting of the diagnosis. Seeman (1995) identifies a similar phenomenon, querying whether the type of relationship formed is either a genetically programmed role or one evolving based upon family interaction. She questions if the relationship response represents socially sanctioned dependency and compliance in women versus learned autonomy and rebelliousness in men.

For a clinical nurse specialist (CNS) in the team 'surveillance' was a key part of work as 'engaging individuals in treatment and monitoring their progress' is fundamental to community based care (Phillips et al. 2001:773). Indeed Wallace et al. (2005) estimate that when working in the community, nurses engage in 'surveillance' in 60% of their interactions with people. In daily practice Angela operated with a clear objective to manage her 'surveillance' role; she tried to contact each person assigned to her care a minimum of once in each three-week period. She maintained a spreadsheet in her diary with a three-week cycle that logged each contact. The basic mathematics of this approach meant that Angela could at best provide a maximum possible engagement of twenty minutes with each person in each 3-week period. CNSs performed 'surveillance' in both formal and informal settings, either by appointment as in a

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65 In the study Wallace et al (2005) found that 95% of the people the community mental health nurses worked with had a diagnosis of schizophrenia

66 This figure is calculated on the data sourced in the 'Description of the field', based upon the possible clinical contact time available following deductions for administrative time, meetings and travel.
regular review at the ‘clinic’ or in a location agreed with the person. An informal encounter could also satisfy the ‘surveillance’ function, such as chance meetings with people in the community; then written up as a review to ‘satisfy’ the ‘3 week’ contact.

‘Surveillance’ was also an ‘institutionalised’ component of team working, incorporated into the pro forma care plan, in the first section of identified needs, under mental health (Fig. 14). Here, a designated team member was responsible for assessment, treatment, and monitoring of psychiatric symptoms and medication side effects. In the case of Andrezej and the other people to whom I was allocated my name appeared in the ‘by whom’ box.

‘Surveillance’ or ‘stalking’

My dissonance in relation to surveillance had its root in the imperative of ‘prescribed’ action; as a ‘prescribed’ action I took the delegated ‘monitoring’ role seriously. As described in the previous chapter, I embarked upon a course to develop a relationship with Andrezej based upon an educative approach in an attempt to develop his capacity to cope with his voice hearing experience. Initially, I tried to incentivise my meetings with Andrezej by offering to meet in coffee shops and restaurants, personally covering the cost of refreshments. However, Andrezej kept only three of the 15 appointments as arranged. In trying to get engagement with Andrezej, I would try to find excuses to meet rather than openly admitting to the ‘surveillance’ process, such as contacting to check on supplies of medication or to provide prescriptions. Yet, even when we did connect, from day to day I could never predict how able Andrezej would be to engage with me. On four occasions, he was hung-over following alcohol/substance use, on another severely physically beaten; his eye bruised almost closed with a contusion following a fight the night before. On two other occasions, he was very drowsy, maintaining this was the effect the full dose of medication had on him (Quetiapine 700 mgs), and on another two he was distressed hearing voices.

With Andrezej, this meant that it was hard to make plans, as I would not know what to expect from day to day. I hoped to base my approach to engagement using structured education sessions, to help Andrezej understand and cope with his experiences, but this did not prove practicable. I could only work with Andrezej when he was able to concentrate. I tried to accept this working relationship, trying to stay onside, trying to accept that this was how it was. I believed that confrontation would prove counterproductive.

Midway through our relationship, however, I noticed that I attempted less to provide educational intervention and more on compliance monitoring. Our engagements became more
casual and opportunistic in nature. To reduce the discomfort I felt from Andrezej’s non-engagement, I found ways of forcing the engagement. I shifted meetings to his home, trying to arrange times when I thought he would be there. I then turned to making contact with Andrezej’s family, telephoning his father, or dropping into the family home, but these strategies met with limited success. Ultimately, these actions triggered conflict in the home:

“Andrezej did not answer his phone. I rang his father to see if he knew where he was or if he was going to come. He said he was still in bed. His father woke him. Andrezej sounded groggy. He said he would not make the appointment, as he had no transport. I said I would be there in five minutes. I would bring him. I felt this review was important. I called to the house, voices were raised, Andrezej and his father were arguing, he almost fell out the door. He had been drinking the night before. He was still under the influence and he was hostile. As I looked at his father and mother in the kitchen, I felt sorry. I felt it was probably my actions that had started the argument.”

Field note: Wednesday, Week 30

When Andrezej dropped out of contact, if I saw him in the neighbourhood whilst making other home visits, I noted his ‘whereabouts’ or pulled over on the side of the road to ‘ask’ how he was coping. On my return to the clinic, I would document the encounter. Because of the doubt about Andrezej keeping appointments or his capacity for engaging, I would attempt to work on the most pressing matter that troubled him on the day.

The dissonance I experienced over failing to get Andrezej to engage, felt more intense because my name was assigned in the care plan ‘by whom’ column. I felt it reflected the responsibility for the safety of Andrezej and potentially his family or others back on me, increasing the sense of my accountability in his care. It had an effect of magnifying my own insecurities in my ability to meet their needs. Andrezej’s inability to cope with his voice hearing experience, I perceived as being the result of my failure to provide him with skills or interventions he needed, his failings reflecting back what I saw as both the team’s and my failing, and a diminishing of my value and worth as a team member.

My frustrations grew as every missed appointment by Andrezej caused me progressively greater inconvenience. I felt let down; I believed that I was making an effort but did not feel Andrezej reciprocated. There appeared few boundaries that I was not prepared to cross to get Andrezej to engage. As a rule, team members would not use families as ‘go-betweens’, however this was a rule, which the team was prepared to break when working with people with a diagnosis of ‘schizophrenia’. I too would bend and in the end break the ‘rule’. On two occasions, unable to contact his father and mother, I turned to using Andrezej’s younger sister, who I thought to be about 15, in an effort to ensure he had a sufficient supply of medication. By Week 32, my dissonance from Andrezej’s non-engagement took on a new form, as a crisis of conscience developed regarding my behaviour. I noted:

‘...the difficulty that I encounter in the practice environment is at what point do ‘assertive’ practices turn into stalking?’

Field note: Saturday, Week 32
I was aware that the nature of my relationship with Andrezej had changed; it made a transition from a therapeutic engagement to one of ensuring compliance with his treatment plan and the medication prescribed. I questioned whether the relationship had made a transition from ‘monitoring and treatment’ to ‘stalking and compliance’ with the team’s way of working. I felt I was giving up on my own beliefs and value system and accepting the ‘psychiatric’ form of management. I felt my ‘cognitions’ changed (Cooper 2007), becoming more accepting of the approach.

In Ireland, the Non-Fatal Offences Against the Person Act, 1997, Section 10 defines ‘harassment’ as the actions of:

“Any person who, without lawful authority or reasonable excuse, by any means including by use of the telephone, harasses another by persistently following, watching, pester ing, besetting or communicating with him or her, shall be guilty of an offence...

...a person harasses another where—

(a) he or she, by his or her acts intentionally or recklessly, seriously interferes with the other’s peace and privacy or causes alarm, distress or harm to the other, and

(b) his or her acts are such that a reasonable person would realise that the acts would seriously interfere with the other’s peace and privacy or cause alarm, distress or harm to the other”

Irish legislation differs from that of the UK, where the presence of Community Treatment Orders (CTO) introduced in 2008, provides for ‘compulsory’ intervention. Yet Firn & Molodyski (2011) argue that there is no evidence that forced engagement and coercion improve the outcomes of care in the community. Presently Irish mental health law does not delineate the boundaries where engagement encroaches into harassment.

Priebe et al. (2005) identify that a key reason that people fail to engage with services is because of loss of autonomy and identity. They also fail to engage because they feel the service does not adequately deal with the side effects of medication. Participants, who had better engagement, did so because they felt the service permitted a move away from a medication focus, that they had a say in decisions, received practical help, and were part of smaller caseloads. As identified earlier, I attempted to use these principles whilst working with Andrezej. Supporting the use of perseverance and using the analogy of a “velvet bulldozer”, Chinman et al. (1999:155) believe persistence is the main catalyst for positive change and engagement with services.

We must consider the role of surveillance in the context of whose needs it serves. Giddens (1984:2) considers that ‘human social activity is recursive’, continually recreated by social actors, based on the ‘needs’ of both parties. In surveillance, we see a source of dissonance arising from a dual need. In the mental health setting, relationships develop that become a product of a mutually sustaining interaction between the two parties, nurse and service user. John, previously given a diagnosis of schizophrenia, explained the nature of the relationship with his nurse:
“This sort of a relationship develops and it is built out of each other’s need. One needs to be a nurse and to be seen to be doing a nursing role and the other is to try and have someone that has contact with you, that knows your sort of history, knows where you have come from and that you don’t have to start, in many ways developing a relationship with somebody that has no background around you or no understanding around you and decide to tell her, to tell somebody that I have been in hospital or I have this diagnosis or what way it is”.

An immediate test professionals may apply concerning surveillance is in asking the question as to whose needs are ‘being met’. Frequently, there is a mismatch with the professionals’ morals and priorities, and those of the person for whom they care (Graham 2006). Shepherd et al. (1995) identifies the deeply differing perspectives of professionals and service users. When a person avails of a service it also serves the need of the service, for the service to exist they need the person. With the diagnosis of schizophrenia when people try to disengage, the service then forces its attention upon them.

My relationships certainly had a multiple purpose. As in Graham (2006), I wished to be seen as performing my duty. I wanted the satisfaction of being efficient and competent. I wanted to ensure both the team and I were covered legally. Yet, this is tantamount to defensive practice. My professional status dictated that I should follow guidelines and evidence. Where an individual asserts independence in mental health services, he or she becomes labelled as ‘problematic’. However, the alternative to rebellion is that the person becomes subservient to the service and ultimately dependent.

Trying to strike an ‘ethical’ balance in ‘surveillance’

Trying to find a balance between individual autonomy and a social control mandate creates complex dissonances. Firn & Molodynski (2011:212) identify that the values of nursing professional ‘codes of conduct’ are ‘well known’ and founded on ‘ethical and moral optimums’. The principles of these codes identify the need to put the interests of service users first, to have respect, and to uphold confidentiality. However in attempting to do this, Stovall (2001) identifies that there are clear ethical conflicts for staff working assertively in community based care, chiefly between the areas of beneficence and autonomy, and beneficence and non-maleficence. In the case of non-maleficence, this applies both to the person diagnosed and to the wider community. Frequently, this can become a balancing act with professionals torn between an individual’s personal autonomy and community safety. In the resultant tension, professionals may resort to the coercive treatment of those they identify as at risk.

The concept of ‘risk’, although poorly defined or explored, has become the single most important consideration in determining access to services and in the allocation of service resources (Foster 2005). Murphy-Lawless (2012) considers formalised risk management procedures are put in place to serve the interests of health services and consequently, in an Irish context, the auspices of the state. Each person referred to the CNS team with a diagnosis in the ‘schizophrenia spectrum’ required on-going monitoring because of perceived ‘risk’ to
others or themselves\textsuperscript{67}. This included all of the people identified in the study. Andrezej’s risk was related to the fear of re-emergence of symptoms due to non-compliance with medication and a ‘potential’ for violence. Aisling was also deemed a risk for non-compliance, actively symptomatic hearing voices, and suicide. The service considered Greg a risk, owing to his poor compliance with anti-psychotic medication and his threat to self-mutilate a year earlier. The team identified Brian as a danger to others, because of paranoid ideation, ‘possibly’ active hallucination, and ‘possible’ non-compliance with medication. Sarah, they considered as symptomatic, experiencing strange thoughts. Where the team identifies ‘risk’, surveillance became the overwhelming ‘raison d’etre’ for nursing actions almost to the exclusion of other ways of working.

In line with policy, the consultant psychiatrist would generally not consider discharging any of the people in this category or discontinue treatment with ‘maintenance’ anti-psychotic medication unless he or she was symptom free for a period of two years. When a person attempted to leave the service or discontinue medication, the consultant directed the psychiatric registrar and key nurse to dissuade him or her from making such a decision, and directed them to inform the family, both of the decision and the potential consequences. The information communicated by staff would place an emphasis on the consequences for both the service user and their family members, should the person decide to leave the service or stop medication. As will be seen later, nurses were generally less supportive of service user attempts to withdraw from medication.

The dilemmas of surveillance centre upon risk containment and the role of mental health professions. One of the mandates of registration and accreditation bodies such as An Bord Altranais is to ensure protection of the public. In this regard, professionals and accreditation bodies are accountable to the public. However, when acting for society in a public safety role, there will always be a bias towards society’s demands and in the diagnosis of schizophrenia, with a culture vested in a risk society, the mandate for protection shifts, prioritising the public ‘plural’ over to the public ‘individual’. But in this instance Graham (2006) believes rather than the service meeting the needs of the individual, the individual meets the need of the service and the service action becomes that of ‘stalking’.

There is a delicate balance in the provision of autonomy for people receiving treatment and the greater good in the context of non-maleficence and justice. In this discussion, the rights and wrongs of the surveillance role swing with the political and social climate of the day but the dilemma remains (Firn & Molodynski 2011). Political action followed the homicide of Jonathan Zito in December 1992 by a young black man, Christopher Clunis, given a diagnosis of schizophrenia and lost to follow up by the mental health services (Laurence 2003). Christopher Clunis received a diagnosis of schizophrenia in 1986. He had a history of violent and aggressive behaviour. Authorities released Christopher from psychiatric care under the UK’s then new ‘Care in the Community’ programme weeks prior to the killing. Eight days prior to the attack Christopher, who had discontinued medication, was reported wandering the streets with a

\textsuperscript{67} The risk to others comprised potential for violence, threats of violence or a previous history of violence towards others. The risk to self was more widely interpreted, extending beyond possible risk of self-harm or suicide to self-neglect, the presence of hallucination or delusion, non-compliance with medication, anti-social behaviour
screwdriver and breadknife, threatening children. Services took no action. The Ritchie Inquiry into the death of Jonathan Zito found that the professionals monitoring Christopher Clunis were responsible for a catalogue of failures and missed opportunities in his care. The case was one of a number of high profile cases, the effect of which, now dictate that the UK legislates for compulsory follow up and treatment. Ireland has not yet embarked upon compulsory treatment. However, Cork widow Una Butler, whose husband received care for depression and took his own life and those of their two daughters, has opened discussion in the media on the need for mandatory risk assessment of people contacting mental health services. She also seeks amendment of the Mental Health Act (2001) to ensure medical personnel include the partners and families of service users in care. Although acknowledging that involving the family is not simple and people who use services have rights, the Minister of State with responsibility for mental health, Kathleen Lynch, has indicated that she would forward communications on the case to Mental Health Commission for its consideration.

When ‘ambivalence’ invokes coercion

A common response to the presence of a nurse in a ‘surveillance’ role is that of ‘ambivalence’. In an attempt to establish relationships, which will allow nurses to fulfill the surveillance role nurses will force engagement ‘assertively’. Here there is a fine line where attempts to force engagement become coercive, and result in dissonance.

Where team members encountered difficulties getting people to engage, as in Andrezej’s case, they frequently used the term ‘ambivalence’ or ‘ambivalent’. ‘Ambivalent’ became a label within the team, a signifier of a difficult ‘non-engaging’ person, of itself a rationale for the service to be involved. The term surfaced regularly in the ‘commitment to treatment plan’ section of the treatment and care plan (Appendix 13). Lüscher (2011:196) credits Bleuler (1910) as first introducing the term ‘ambivalence’ to a medical/scientific context, when he used it in schizophrenia classifications to describe the ‘conflicting experiences’ and ‘polarized tensions’ that limited a person’s ability ‘to act consciously and responsibly and to consider alternatives’. Responding to its use in the team (effectively socialised into the term), I found myself using the term ‘ambivalent’ regularly in my reports on Andrezej. As outlined earlier, my initial attempts at getting Andrezej to engage centred on agreeing scheduled appointments, effectively setting a time and place where we could meet and talk. This was the service’s expectation in relation to engagement.

My dissonance from people’s non-engagement came from a number of conflicting standpoints. The first came in the form of my dilemma as a nurse between ‘I want to help’ v ‘I am not being allowed to help’. In addition, two sets of values clashed, those of the team criteria ‘we want you to engage: don’t waste our resources’ and those of my own internalised model which proposed ‘I want to help you cope better/I want you to have autonomy/you should be able to decide for yourself’. Nevertheless, even my own perspective was conflicted as I felt ‘if you do what I say, you will cope better’. All of these confusing sentiments created the climate for dissonance and over time, with Andrezej’s fractured pattern of engagement, my frustration and annoyance grew.

I began to look for increasingly inventive ways to encourage engagement. Perceiving my poor engagement with Andrezej as a reflection on my ability or inability and my value to the team, I
actively contemplated using coercion, albeit using what I regarded as ‘subtly’ coercive strategies. I approached the team’s consultant with a plan, as to whether he felt it would be legitimate to use access to social welfare payments as a lever in getting a greater level of engagement from Andrezej. Knowing that the social welfare department denied Andrezej access to Disability Benefit on residency grounds, he turned to the Community Welfare Officer to obtain emergency financial support. In order to access this, Andrezej required completion of a formal declaration by his treating doctor verifying the diagnosis of schizophrenia monthly to entitle him to financial support. The consultant and I discussed withholding the signature unless Andrezej was prepared to engage with the treatment plan. On the first occasion I suggested it, we agreed that it would be inappropriate to withhold the signature, as Andrezej’s access to benefits, given the recognised ‘disability’ status of schizophrenia; was a civil right. As Andrezej’s engagement over time failed to improve, the consultant suggested using a modified version of this course of action. Rather than returning the form to Andrezej’s home or send it by post, as happened in other instances, Andrezej would need to make contact in person to obtain the form. He needed to collect the form from me personally at the clinic, at an agreed time. The outcome was simple, non-engagement equated to no form and no money. Andrezej attended in person to collect the form. He brought the form to the community welfare officer and his benefits resumed. Andrezej and I arranged a new appointment, which ultimately Andrezej did not keep and my pattern of chasing for engagement resumed.

In the case of Andrezej, our actions straddled a line between inducements and threat. Wertheimer (1988) argues that a decision to impose conditional access or remove an entitlement, such as a social welfare benefit, that leaves a person in a worse off condition constitutes coercion. He contends that people need to use a ‘moral baseline’ to interpret the nature of coercion. In the case of a proposal, he considers that the recipient should not be worse off because of the action/non-action. Monahan et al. (2005) found that between 44 and 59% of people experience some form of ‘leverage’ for engagement in mental health care. Their results show between seven and nineteen per cent of these people encounter coercion based on money. Yet, Monahan et al. (2005) report that thus far US courts have not upheld any legal challenges to the use of this form of coercion, as rulings considered its effect was minimal.

**Dissonance from attempts to ‘control’ people**

How staff attempt to control people can also result in dissonance. Presented in this section are three forms of control, i) using ‘symbols’ of schizophrenia in the form of assessments, to reinforce illness perspectives and to establish the ‘professional’ dynamic of relationships, ii) using ‘banishment’, to create fear of abandonment by the service and iii) using ‘punishment’ to re-establish ‘professional’ boundaries in relationships.

As highlighted in Chapter 3, Lipsky (2010:86) argues that in an effort to cope with the dilemmas they face in practice, a street level bureaucrat will endeavour to ‘husband resources’ and ‘control’ service users. During a discussion of my work with the psychiatrist over coffee, I identified the role of ‘control’ as an issue in mental health care. He replied:

‘...but we do very little control; at most 1 to 2 per cent of our patients are non-voluntary’
The psychiatric nurse working within the community mental health team played a key role in control; effectively training the person as to the expected behaviour associated with the team. The consultant’s response summed up the team’s perception of how it interpreted the extent of its ‘control’ in the lives of the people it worked with. To the team ‘control’ meant the team forcing people to have treatment in a non-voluntary capacity. Team members did not see in the nature of engagement, how their actions imposed a system of control and introduced ‘self-subjection’ that extended over the person’s life. Here nurses used a number of coercive strategies that can create dissonance when explored in the full context of action.

In surveillance, the psychiatric nurse uses each encounter with a service user to gather material for on-going assessment and in this process of ‘examination’, surveillance makes a transition to control. The most visible illustration of this surveillance was evident in the form of the structured assessment, with the range of assessment tools described in chapter four. During the study, nursing staff conducted most of the structured assessments of service users, as the team’s clinical psychologist and social worker commented upon in an aside during a team meeting:

“...it appears that assessment has now become the nursing preserve...”

Field note Monday, Week 14

This was true, as following an initial assessment by the consultant psychiatrist; the homecare team nurses conducted all of the formal assessments. The use of formalised assessment extends psychiatric power and imposes control, as the following episode illustrates. In conjunction with my on-going informal evaluation of adverse effects of medication, I completed a six monthly Udvalg for Kliniske Undersøgelser (UKU) Side Effect Rating Scale assessment (Lingjaerde et al. 1987) on Sarah. This was one of the core structured assessment tools used by the nurses on the team to evaluate service users’ experiences of medication. Yet, I wondered what function this assessment ultimately served. It took approximately thirty minutes to complete, and provided a comprehensive assessment of all of the possible effects the medication might have. However, it clearly placed Sarah in a position of inspection, asking probing questions about intimate bodily functions. Following the assessment, I reported and filed it. Whereas the homecare team acidulously completed these assessments, Angela, Regina and Shannon rarely used formal assessments on the people they worked with, Angela explained she did not:

‘...have time to complete them... [and the assessments] ...tell me little I don’t already know’

The Udvalg for Kliniske Undersøgelser (UKU) Side Effect Rating Scale is a clinician-administered rating scale, used to assess adverse effects of psychotropic medications. Data is obtained through both interview with the client and observation made by the clinician. It consists of 48 questions and the assessment takes approximately 30 minutes. The clinician makes the evaluation on the presence of features up to 72 hours prior to the assessment. Ratings of zero, one, two or three are assigned depending on the degree of severity. Zero indicates normal; one indicates mild symptoms; two indicates moderate symptoms; and three indicates severe symptoms.
Outside of being an 'aide memoire' for the areas that I already knew needed assessment, I questioned what did doing this assessment bring? I felt the assessment told me nothing that I did not already know about Sarah. While an assessment is supposed to be a source of information for action, Gamble & Brennan (2006) identify that nurses’ use of assessments in most cases serves as an end in itself, and in practice findings are rarely carried forward into care plans. Higgins et al. (2006) identify that nurses rarely act on the occurrence of adverse effects and do not attempt to see how they can minimise them for service users. Healy (2012) identifies that on the rare occasions that staff report adverse effects even drug regulatory agencies do not act.

However, using the structured assessment made me feel comfortable with exploring the adverse effects to medication, which previously I felt uncomfortable about querying and might otherwise omit, such as sexual side effects. Here under the guise of comprehensiveness, I was justified in asking all of the questions and not leave myself open to an accusation of being inappropriate. It allowed me to use my ‘professional’ knowledge; it provided legitimacy to our meeting and allowed me to present a professional front to Sarah. In carrying out the assessment, I was clearly a nurse and Sarah my client.

From a dissonance perspective, in my eyes, the assessment served to reinforce Sarah’s reliance on medication as the solution to her problems, despite the adverse effects she experienced. I justified the use of the structured assessment tool by convincing myself that it allowed me to utilise a ‘motivational interviewing’ approach, and enhance compliance by being able to talk up the benefits that Sarah’s atypical anti-psychotic brought over the cost of the adverse effects she experienced. In truth, this was not necessary; Sarah was already convinced of the need for medication use and its effectiveness. So really, why did I want to use this assessment? I wanted to use it because it was there, because it legitimised my role and gave the impression that I was a ‘professional’. After I completed it, nobody else was interested in its outcome, despite my attempts to highlight the results to the registrar and consultant. I exercised knowledge and power in a formal way that legitimised my position as a psychiatric nurse; and as a result, Sarah’s could ‘depend’ upon me as ‘her’ nurse. I legitimised the medicalised identity, which Sarah assumed. In reinforcing the importance of medication, I reinforced with Sarah the notion that medication was the solution to her problems; as I later saw when faced with increased suspicious thoughts; Sarah would only see medication as the solution.

The second ‘control’ strategy that caused me dissonance was using ‘banishment’. In addition to using the ‘monetary’ incentive to engage Andrezej as discussed earlier, I used the threat of ‘banishment’ (Christensen 1995), to induce fear that the consultant would discharge him over his lack of engagement. This was despite knowing the distress that his voices caused him. Yet,

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69 Motivational interviewing (MI) is a style of patient-centred counselling used to facilitate change in health-related behaviours. The objective of MI is to change patterns of behaviour that have become habitual and reduce behaviours that interfere with therapy. It employs a directive style aiming to help people explore and resolve ambivalence to behaviour change. Two components are generally acknowledged in the approach, style (warmth and empathy) and technique (e.g. focused reflective listening and the development of discrepancy). The principles of MI acknowledge that for change to happen a gentle process of negotiation is needed. The process requires that change occur through the person articulating the benefits and costs involved. Conflict is unhelpful to the process and a collaborative relationship, tackling the problem together, is essential.
as a dissonance reduction strategy for ‘non-engagement’, using ‘banishment’ generated dissonance. I initially noted:

"Andrezej was due to attend the centre today, his outpatient review was due. I had arranged the appointment especially as he needed medication, and his voices had resurfaced. I had phoned to remind him the evening before precisely to avoid this situation. It had been agreed at the team meeting no presentation; no medication. The doctors generally did not operate outside appointment times; at least not for a client perceived to be “messing around” with the system."

Field Note, Wednesday Week 27

The team applied its own version of the ‘Three Strikes Statute’. Missing three consecutive appointments with either doctors or nurses triggered an automatic response in the service. The consultant operated from a simple premise: if the person considered the problem were important enough, he or she would be there. If they did not attend, then why should we waste resources if the person was not sufficiently bothered? Put simply ‘...you buy the package’. The service, regarded engagement as an all or nothing concept. If people did not adhere to the treatment plan, then they could seek treatment elsewhere. Christensen (1995) suggests mental health services cite the ethical principle of ‘justice’ to justify such actions.

At team meetings I gave updates on Andrezej’s engagement and adherence to the treatment plan. After more than five months of actively attempting to engage Andrezej, the team discussed whether it was appropriate to continue working with Andrezej. The consultant deemed that I had:

‘...taken the concept of ‘assertive outreach’ and working flexibly as far as was humanly possible’

Equally, team members conceded that a rigid approach had not worked with Andrezej either. The team needed to operate within finite resources. Andrezej already missed two consecutive medical outpatient appointments and I could no longer make contact with him, all of the mobile phone numbers that I had for both Andrezej and his father went unanswered. There was no response at the house on the previous three occasions when I called. The team removed Andrezej from their ‘books’, referring him to his GP for care. They had an established pathway for ‘banishing’ people who did not engage with the service. The consultant’s secretary kept a series of template letters on file for this purpose. The consultant psychiatrist signed a ‘form’ letter notifying the person that he would discharge them from the service in two weeks, unless the person made contact expressing an intention to remain with the service. If the person made no contact, the secretary sent a second letter notifying the person of their discharge. If the

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70 You may not consider the language appropriate however; this is the language used in relation to Andrezej’s behaviour. It accurately describes the sentiments prevailing within the team towards Andrezej at the time.

71 Several of the state governments of the USA enacted ‘Three Strikes Statutes’ in the 1990’s. These laws severely punished habitual offenders who received longer prison sentencing following two or more felony offences (White, 2006)

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person wished treatment after that time, they needed a new referral from his or her general practitioner.

I raised concerns about this, as I believed neither Andrezej nor his family would be able to read the letters. I had seen first-hand his lack of reading skills when the social welfare department sent notification of his appeal against the refusal of disability allowance. He could not read it; he ignored the letter and consequently, lost the right to appeal the decision. At the meeting, this did not seem to concern team members. This was the mechanism; if we could not find the person, how could we do anything else? If Andrezej contacted us, we would refer him to his GP for care. The team rationalised, Andrezej’s family could remind him to take the medication that might be enough. There was no response to the letter and the consultant told me that I should no longer follow up.

The manner in which the discharge letter process operated effectively served as documentary evidence that the service ‘had washed its hands’. It felt like ‘defensive practice’, the preparation of an insurance policy for the day when the service might end up in court having to account for its role in Andrezej’s actions. I could hear the case in ‘court’:

‘We tried but Andrezej rejected us, what more are we to do? We fulfilled our statutory duty. We tried to protect him from himself; we tried to protect you, the public, with all of the provisions afforded to us under mental health legislation. We gave the individual the choice to engage and accept treatment; it was his failing not ours and here is our evidence to prove that we were not negligent in our actions.’

The situation illustrates how dissonances become more complex. I was an unwilling participant in the decision to enforce the rules, but complicit all the same. I reached a point of exasperation; part of me welcomed the decision to discharge Andrezej, as I felt I had run out of ideas. My actions in meetings highlighted his non-engagement; this was partly motivated by my desire to prove myself as a member of the team, but it brought to the fore the ‘rules of engagement’ that the team applied. My actions would force their hand in ensuring they ‘justly’ applied the rules. I still struggled with the service’s model of care. As a service, it appeared to be still trying to create a ‘patient’ for the service. I reasoned that maybe Andrezej was better off without the service and my dragging him back into ‘our’ clutches might not benefit him in the short term. In its use of ‘banishment’, the service did not have the time or resources to stretch for engagement, strangely enough, it appeared neither did Andrezej. He did not appear receptive to the service’s provisions or to be willing to explore his voice hearing experiences. When he took the medication, the voices were not problematical. He became just like any other ‘teenager’, a bit out of control, at odds with his family. He maintained a constant relationship with his girlfriend through almost the year that I knew him. He always dressed well, and kept himself well groomed. His friends accepted him; on three separate occasions when on calls to see others in the neighbourhood when I passed him by he was always at the centre of the group, he appeared equal to his peers both in stature, age and involvement in what was happening. There was no evidence of stigma, and I rationalised perhaps he did not need the stigma of engagement with the service.

‘Banishment’ raises considerable ethical dilemmas in mental health. Younggren & Gottlieb (2008) discuss the concept of ‘termination’ when discharging people from psychological
treatment; they outline the criteria that need establishing before for a unilateral cessation of care:

1. Does the action adequately address issues of 'informed' cessation?
2. Is there an adequate record of the decision and process?
3. Were others consulted and did they concur with the determination that termination was appropriate?
4. Was the termination model consistent with the orientation of care?
5. Did the termination respect the issues with which the person struggled?

I still was uneasy with the decision, but the team appeared satisfied. We can consider Andrezej’s case, in the context of Christensen’s (1995) ethics of treating the ‘untreatable’. The team believed it had done all it could, so they adopted a 'tough love' stance in 'banishment'. We can consider the decision from a normal ethical standpoint using the criteria of beneficence, autonomy, and justice. Applying the principle of beneficence, the team believes its actions promote Andrezej’s best interests. It may also consider that the decision fulfils the autonomy principle in respecting Andrezej’s decision. We can interpret his non-engagement, despite his expressed desire to remain in treatment, as tantamount to a declaration of his right to refuse treatment. In addition, the team may consider their action respected the principle of justice, believing team resources are not wasted, and that their actions are ethical in attempting to allocate resources in a just and fair manner. In this, the principles are ethically defensible, however, Christensen (1995:1217) argues that ‘application of static ethical principles... may provide tightly reasoned and defensible positions' but they are insufficient to consider standards for mental health treatment in the case of the ‘untreatable’. He offers a new standard for ethical consideration in such circumstances; the ‘traditional virtues of compassion, humility, and fidelity’, which he believes, are now a neglected aspect of ethical care. He reasons that unless we revise our standards of ethical reasoning, then those categorised as 'untreatable' will be constantly at risk of exclusion and in using limited ethical reflections there will always be justification for their 'banishment'.

Applying a principle of compassion compels us to abide by people and treat seriously the enduring nature of the problems they experience and can counterbalance the inclination to apply the justice principle ‘with callous disregard’ when working with people considered ‘untreatable’ (Christensen 1995:1217). With the principle of humility, Christensen (1995) asks us to consider our ‘humaness’ and ‘fallibility’ in the decisions we make. Tempering the belief of infallibility, humility offers the capacity for us to question whether we truly operate in the person’s best interests or ‘do we act for our own’. Finally, in fidelity, Christensen (1995) reminds us that that even when people refuse the treatment we offer they still retain a right that endures, one which we should not abandon when challenged by a lack of engagement.

Four weeks later, two weeks after the deadline expired, Andrezej arrived back at the health centre. He had the letter in his hand. Without medication, he felt pressurised, his distressing voices returned, and he wanted help. I raised his request with the consultant. He agreed to allow him to return but he stated if he ‘really’ wanted help, then he would be obliged to abide by the service’s terms of re-engagement. I explained the terms to Andrezej and he agreed. The medical registrar examined Andrezej, identifying the presence of ‘voices’ as a symptom of
'paranoid schizophrenia'. He asked Andrezej why he was not engaging. Andrezej maintained his girlfriend wanted him to disengage. He stated that he wanted to have medication and to stay with the service, maintaining his family supported this. I terminated my fieldwork shortly after this episode. When I returned to the area four months later, Andrezej's key nurse, told me the team discharged him after another four weeks, as he failed to keep to the agreement.

Using ‘punishment’ to maintain ‘professional’ boundaries

Both the team and I tried to make people engage on the terms that we dictated, but equally we resented when people's behaviour became one of ‘dependence’ on the nurse and the service. Sarah’s circumstances illustrate the nature of this dependence. With a diminished social circle, many service users with a diagnosis of schizophrenia like Sarah and Aisling, found acceptance in each other’s company. Here they did not need to endure the discomfort of needing to explain their circumstances to others, and may find an acceptance not experienced elsewhere. This was the case for Sarah. Sarah’s life, daily activity and social circle revolved around the service. She depended upon the nurses in the community mental health service and was very reliant on her key nurse. My meetings with Sarah were social events in her life. Sarah clearly enjoyed our meetings partly, and by her own admission, because it would provide her with a reason not to attend her training course at the National Learning Network. At our meetings, Sarah was always eager to know the gossip in around the clinic. The comings and goings of staff, the well-being of staff on sick leave, happy events, births and deaths, the well-being of the staff's children, leaving certificate results, college offers and new jobs: Sarah lived her life vicariously through those associated with the clinic. She would query the progress of nurses’ children in school or college, buy presents to mark events such as a birthday; always just small enough that staff felt they did not need to refuse them under the service’s policy and ABA code of not accepting gifts.

As the number of people allocated to my care and their levels of need increased, I found I had less flexibility in the time I could spend with people. The aspect of boundaries took on significance at this time, as Sarah sought more contact time with me. Early in my relationship with Sarah, I identified that she initiated a number of phone calls in the guise of a problem or crisis, which were directly proportional to the frequency of meetings. The greater the interval between meetings, the more ‘problems’ Sarah would seem to encounter and consequently, the more time I would need to spend on the telephone trying to support her. In addition to our meetings and phone conversations, over the period of 151 days during which I kept a log, we exchanged 125 text messages; Sarah initiated seventy-one of the text contacts.

People using the service had protocols if they needed assistance outside of regular service hours. What I would now like to examine is my response to an episode of Sarah’s behaviour that arose from a ‘breach’ of that protocol, which placed me in a compromising position. In

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72 I had not realised the significance of this form of contact in the initial stages of the fieldwork, the 151 days were from the point of my noting to the conclusion of my fieldwork as key nurse. It was not possible to identify the number of phone conversations we engaged in, as these were spread over a number of telephones both mobile and service landlines.

73 If a person required assistance out of service hours (9am-5pm) they were told they should contact the Inpatient Unit at Rathmullen Hospital where they would either advise on suitable treatment or refer the person for review at the Accident and Emergency Department. A message was configured on the service telephone also advising this.
response, I felt I needed to establish 'control', in Foucault's words to 'create a docile body', under the control of the service. Lipsky theorises that street level bureaucrats apply sanctions to 'punish' people who do not conform to its routines; such as small penalties, used in a coercive manner, to bring about changes in the person's pattern of behaviour. My response reveals a deep-seated dissonance, caught between two inconsistent notions, namely 'nurses are caring' versus the sentiments that 'I was punishing a person whom I was expected to care for, when she was distressed'.

Sarah sent the following three text messages (56-58) over the course of a Sunday evening and night at 16.41, 18.25 and 22.23:

Mark I am afraid this can't wait til mon. Received a text on Sat morn and thought straight away it was from XXXX (ex-boyfriend) so I deleted it straight away. It was a loving text then I began to think it was from XXXX (the man for whom Sarah had expressed intense feelings). If it had been it would have put a whole different complexion on things. If I had saved the text I could have replied. I so want it to b from him. U don't have to reply cos it is the weekend but I would appreciate ur help!!

Text message 56

I know it was XXXX (man Sarah was infatuated with) Just hoping I haven't ruined things. Talk tomorrow.

Text message 57

Mark! I know there's 'manners' and 'not contacting ur nurse on a Sunday night' and I know it is 'not an emergency' but I'm here waiting for a txt that'll never come but I need your 'logic' to put some 'perspective' on the situation or I won't sleep tonight (quotation marks used by Sarah in text).

Text message 58

I received text 58 on my way to bed on Sunday night and read its contents; it triggered an inconsistency for me. I was concerned; I felt I should respond to relieve Sarah's distress but in doing so, I would set a precedent possibly opening myself to further and possibly more serious breaches of protocol. If I respond, I would have failed to uphold the 'professional boundaries' to which my colleagues adhered. I was also very angry, as I felt in a compromised position. I worried that my failure to respond might trigger an impulsive act on her part.

Perkins et al. (1998:1317) believe boundary issues are common in everyday practice but nurses do not always deal with them 'conservatively'. They maintain even professionals with high levels of education and training still encounter dilemmas that put their values in conflict. Boundary breaches not only threaten the care of the person; they can also cause distress for professionals. From the content of the texts, it was clear Sarah knew the protocol for contacting the service after hours. Although acknowledging that it was not an 'emergency', Sarah's reliance on me, her key nurse to alleviate her distress, as the only person capable of applying 'logic' brought about the boundary breach. I interpreted Sarah's response as a reflection on me that I was wrong not to have responded earlier. I felt Sarah's boundary breach was an attempt to transfer the blame for not being able to sleep away from her thoughts onto me for not
responding. Yet, to my mind, I was not the person who had crossed the boundary. I wanted to respond, I wanted to castigate Sarah for her disregard and placing me in a compromised position, but I resisted this. I resolved that I would not respond.

In practice, nurses frequently find themselves in situations where their actions or the actions of the people they work with test the boundaries of care. Peternelj-Taylor & Yonge (2003) believe that how a nurse responds to a boundary breach is a challenge to their integrity, given the inherent power dynamic of their relationship with the person. The nurse is expected to 'do the right thing', but as Peternelj-Taylor & Yonge (2003) point out it may not be certain what the right thing is. When I returned to duty the following Monday morning, I did not return the text message or contact Sarah. I discussed with my colleague Regina what had happened. We agreed that it was 'inappropriate' for Sarah to have made contact in that manner. Intent on teaching Sarah a 'lesson', I decided I was not prepared to make contact with Sarah until I received an apology or an appropriate period had passed. Both Martinez (2000) and Peternelj-Taylor & Yonge (2003) consider the area of boundary dilemmas as a "slippery slope" linked into ethical decision making.

In this consideration of Sarah's actions, another dimension to boundary breaches needs consideration, that area being the source of my personal dissonance. Peternelj-Taylor (2002) believes nurses do not regard decisions to 'under-engage' as a boundary violation. She regards failure to engage with people's needs as 'offensive'. She also believes that staff disguise 'under-engagement' by using superficial interaction, failing to address issues adequately or by working to their own agenda. To manage boundaries effectively, therapeutic integrity and self-awareness are essential. Recognising the importance of the awareness of one's own motivations, Peplau (1992:15) considered that a 'nurse who has a strong need to be liked, to gain approval, is very likely to pattern behaviour to satisfy a personal need'. In their attempts to engage people and sustain a meaningful relationship, the potential exists for nurses to step outside of acceptable boundaries. The development of familiarity and trust within the interpersonal relationship can lead to boundary violations with the nurse torn between the desire to help and the need to maintain the boundaries of professionalism. Peternelj-Taylor & Yonge (2003) identify that boundaries guide both professionals and their clients' behaviour and are seen as vital to 'professional effectiveness'. They also consider those who work with people who experience mental health have greater responsibility in managing boundary issues, as breaches contribute to the erosion of the therapeutic relationship.

It is not always easy to find the lines of demarcation in the dilemmas of clinical practice. The therapeutic relationship is by its nature asymmetrically flawed given the inherent power imbalance within. Although my response of 'under-engagement' may not be in the category of an extreme boundary breach, even in 'venial' transgression, there is dissonance. Using Martinez's (2000) framework, I identified that my primary motivation was to retain the

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74 Sexual exploitation has become the focus of boundary breaching discussion with the emphasis on professional responsibility to safeguard perceived client vulnerabilities. The discussions then move to lesser forms of exploitation such as those involving time, money and space. The effects of boundary breaches on the professional appear rarely in discussions.

75 Martinez's (2000) model of boundary crossing offers a four stage hierarchy across the areas of potential for benefit or harm to the person, the presence or absence of coercive and exploitative elements in the
professional standing of our relationship; I felt Sarah’s transgression inappropriate. Drawing parallels with Foucault’s theories, I felt I needed to maintain ‘orderly conduct’; my motivation was to ‘teach’ Sarah a lesson using ‘correct training’ in the eyes of my service colleague. I had not considered it ‘punishment’, but my reflection identifies it as a response of reprimanding a ‘bold child’, not one of trust or respect, but one in the exercise of power.

A week passed, I did not make contact with Sarah; she did not make contact with anybody on the team. This was the longest time that Sarah made no contact with the team for the entire period of my fieldwork. The following Monday morning Sarah contacted the secretary of the team asking me please to contact her. Feeling that sufficient time had passed, I returned her contact, and we arranged to meet the following day. Sarah apologised for contacting me on the Sunday night. It was as though Sarah knew I was punishing her transgression, and felt I had punished her enough. I did not feel guilty at the time, as I did not regard it as punishment, but as a behavioural modification technique. Yet I rejected Sarah and consciously withheld what I felt she needed of me most of all, ‘contact’ and ‘logic’. No more was said. Our relationship returned to its previous pattern. Sarah never repeated the behaviour. I later learned from Aisling that she regularly contacted Angela ‘out of hours’; Angela always responded. I shall return to this exercise of power in the next chapter where I will consider it in the context of dissonance reduction.

**Dissonance with prescribed medication**

*‘For Brutus is an honourable man...’*

Julius Caesar, Act III, Scene II

As a secondary school student, I struggled as my English teachers attempted to drag me through an understanding of Shakespeare’s works. In later years, I came to understand how in their very nature the works contained the essences of humankind and human frailty. Little understanding the ‘rhetoric’ of Mark Anthony’s eulogy, I tried to abide by ‘honourable’ actions. It remains a strong motivator in my behaviour. More than any other, the area of medication and the behaviours of professionals around its use, cause me the greatest levels of ‘inconsistency’. I do not dispute that at times anti-psychotic medication has a role and can help people given a diagnosis of schizophrenia to cope with the challenges their experiences bring. However, the following section illustrates the types of ‘inconsistencies’ that arise in clinical practice from medication use, and the dissonance they cause me.

Medication use generates ‘inconsistencies’ falling into categories of (i) failing to provide choices, (ii) providing of full information on the effects of the medication – good and bad, (iii) acknowledgment of the bad effects when they occur, (iv) failure to believe people’s accounts of their experiences and how these factors conflict with nurses’ desires to maintain compliance with medication and (v) adherence to treatment plans without effecting the status quo of the relationships. From a dissonance perspective the inconsistencies of working with medication boundary crossing, the professional’s motives and intentions, the professional’s aspiration to professional ideals, and the context of the boundary crossing.
compliance triggers uneasiness, and emotions of regret, anger, and remorse in feeling dishonest. I believe that at times my behaviour in respect of medication might fail the test of 'honourable' behaviour.

My dissonance in relation to medication stems from the belief that people with a diagnosis of schizophrenia should be given choice in the treatment they receive. Repeatedly people identify over-reliance on medications as problematical (Mental Health Commission 2005). I asked Aisling whether she believed that she had choices in the care she received:

"... yeah, I think like, I have had a choice, definitely"

Probing deeper, Aisling's clear understanding of choice meant the brand of medication she took:

"...No, they did [give me a choice], like when I stopped taking the Clozaril, then they put me on Seroquel... they say it is my choice, it is up to me to stop taking the Clozaril. When I did they put me on I think it was Seroquel, so and then the Seroquel was not really helpful, it gave me a dry mouth"

Although, when she left the health centre, Aisling was in control, at home 'choice' meant compliance:

"...well it was up to me really, because I was the one that went home"

I found the absence of treatment choice difficult to accept. I wanted to be able to offer choice, but as a practitioner, I had limited skills in working in this way. Alison, the clinical psychologist, attempted to introduce cognitive interventions for psychosis into the team; however, she encountered barriers. She believed the greatest barrier she faced was the team's lack of belief in psychological intervention as an effective treatment, with nurses believing psychological interventions would exacerbate people's symptoms. Alison summed up the nurses' unwillingness to use psychological interventions:

"... if the drugs work, there is no call for psychology"

Alison believed several factors contributed to this resistance, namely the time span needed for the intervention, negative service users' perception and staff difficulty in seeing real benefits in the people that they worked with. These were factors she found hard to counteract; in part due to the type of people referred for cognitive interventions. In her experience, the people considered for cognitive interventions were often those with the most entrenched beliefs and considered 'neuroleptic resistant'. Their care presented the greatest challenges in working cognitively.

When it came to working with people with a diagnosis of schizophrenia, nurses compared the effectiveness of psychological interventions with the outcomes of medication. In the comparison, the reference point was effectiveness in a crisis; they did not appear to see quality of life issues, such as social engagement as a priority. Alison believed these quality of life issues were difficult to evaluate and hard to place a value on. A double standard appeared to exist. Psychology was expected to succeed where medication failed. However, when medication
failed, the blame was placed on the person, as they did not respond. When psychological interventions failed, psychology was ‘no good’.

Following on from the dissonance surrounding cognitive intervention use, closely linked is another source of dissonance arising from the dependence which treatment with anti-psychotic medication can instil. As seen in the foreshadowed problems, the perception of schizophrenia as a biological disorder increases the perception of helplessness and the feeling that medication offers a possible avenue for rectifying biological deficits, but without an ultimate cure. Both Aisling and Sarah’s accounts illustrate the problems this perception creates.

In her analysis of her experiences, Aisling believes there is something wrong with her and she is convinced of her own helplessness and need to rely upon medication:

“I know there is something not right with me ... it is like this person can never be helped like, they can just be given drugs and they are not going to get anywhere, they are just going to keep on giving me drugs and then I rely on the drugs”

Likewise, Sarah’s understanding was similar to Aisling, believing it was the:

“...chemicals in my brain”.

Sarah relied on the consultant’s judgment and was convinced that medication transformed her life.

“Clozaril has revolutionized my life. I can dance again. I have lost the weight.”

Sarah’s compliance with medication was total. At every meeting, she would reiterate her ‘mantra’:

“Mark, I will be alright if I just keep taking the tablets”

However, Sarah’s belief in the value of medication came at a personal expense. Sarah’s body image was of great concern to her, a distinct component of her sexuality. She was disgusted by how weight gain transformed the bodies of her female friends who took anti-psychotic medication. She controlled the potential for weight gain, a side effect of her medication, by regulating her food intake, using smoking as an appetite suppressant, consuming large amounts of caffeine and exercising regularly. The combination of Sarah’s dietary control and clozapine caused severe constipation, which brought her to the accident and emergency department on two occasions that year with suspected obstruction; this was despite using daily doses of Lactulose. Constipation is a very common adverse effect of Clozapine. Hayes and Gibler (1995:298) found 60% prevalence of constipation in a sample of 53 patients treated with Clozapine. Most of the group experienced mild constipation and managed with ‘softeners, laxatives, or enemas, however one severe incidence resulted in death from ‘aspiration of vomitus secondary to bowel obstruction’. In 1994, Sandoz, the then manufacturers of the drug, reported three cases of death to the Food and Drug Administration in the United States resulting from ‘obstipation and ileus’ Hayes and Gibler (1995:298).

Lactulose is a synthetic disaccharide, which acts as a laxative by acidifying the colon. When ingested it is broken down by the bacteria of the colon into acids (primarily lactic but also acetic and formic). These

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her freedom to become involved in relationships. It worried her so; that she would not stay overnight with somebody for fear of incontinence. Sarah danced at classes three times weekly but although regarding herself as very fit, she sweated profusely during them. She became self-conscious of this when her instructor commented upon it. She considered leaving the classes, not wishing to come under the gaze of her fellow students or, become the subject of gossip. When I explained it was in all likelihood due to the medication she never mentioned it again. She continued to take ballet classes.

Sarah had a ‘major crisis’ when she discovered a lump in her left breast. The process from discovery to diagnosis took eight weeks. Over this time, Sarah found it more of a struggle to cope with her suspicious thoughts. She sensed cars had begun to follow her home, when they passed her by she interpreted the meaning in the lyrics that played on the car radios as messages from her former boyfriend trying to reinitiate their relationship. Throughout this period as she tried to cope with increased experiencing of strange thoughts, I became the sounding board for her testing of reality. I was one of three people whom she selected as trustworthy in assessing the reliability of her thoughts. As her levels of anxiety increased, we explored the use of relaxation techniques and although acknowledged as helping, she sought an increase in medication. Given her low body weight and hypotension, Sarah’s consultant was reluctant to increase her medication. Her drug treatment already exceeded the manufacturer’s recommended dose. Following Sarah’s pressure on her psychiatric registrar, an agreement was made to increase the dose by the smallest amount possible. Sarah was happy; she believed that the increase made all the difference to her.

I was deeply divided about my honesty concerning the benefits of medication when compared with the hardship Sarah endured. Throughout my engagement with her, I reinforced Sarah’s belief in the benefit medication bestowed, not contradicting her. Yet, Sarah’s belief was in stark contrast to that of her consultant. He stated he felt ‘Clozapine’ had made no difference to Sarah’s experiences of psychosis, which he considered remained ‘neuroleptic resistant’ over their five-year relationship. He did not want to change the medication as he felt there was no point in unsettling Sarah. Unaware of the consultant’s perception of the lack of ‘real’ benefit. During times of particular distress, I worked with Sarah on ‘reality testing’ situations and using ‘relaxation techniques’ as a form of distraction. Sarah felt these exercises were ‘hard work’ and did not give her the sustained relief that she sought; the sustained relief that she found with increases in medication.

Trusting peoples’ accounts of their medication experiences
Another ‘vicarious’ experience of dissonance I encountered came in the nurses’ failure to disclose the adverse effects of medication, as the following account illustrates. It centres on Aisling, whose most enduring memories of interactions with nurses relate to the use of acids cause an increase in osmotic pressure with an increase in the water content of stools thereby softening them.
antipsychotic medication. From the early stages of treatment with Depixol\(^{78}\), Aisling noted elevated mood, restlessness and agitation:

“...it was making me happy, like, too happy ... I was really hyper and I could not relax, so I felt like it was too much, like I was just keeping busy all of the time ... I wanted to keep doing things”

Aisling drew her experiences to the attention of the nurses. In response to her reports of adverse effects, she felt some of the nurses were avoiding engaging with her:

“...some of the nurses were blanking me a little bit...”

Healy (2009) states that these antipsychotic medications are noted to cause nervousness, restlessness and agitation, collectively described as akathisia, signs that are frequently interpreted as a worsening of mental state. He describes akathisia as akin to ‘mental turmoil’ acknowledging the problem may only be ‘subjectively apparent’ and may manifest emotionally rather than as a motor phenomenon (Healy 2009:28). By the weekend, Aisling was shaking and did not sleep on Sunday night:

“I had a stiff neck, brain was frozen, I felt very vulnerable, overtired ... I was frozen, I couldn’t move, I was pressing my teeth together and emh... and like...oh sometimes...Jesus...I was pressing my teeth together... I was having all of these symptoms...they would not give me Kemadrin”

In accordance with the ‘out of hours’ protocol, Aisling telephoned Meadowfield\(^{79}\) for advice. The nurses advised her to attend the Accident and Emergency Department at Rathmullen General Hospital for medical review. Aisling did not want to call an ambulance and instead called for a taxi; the round trip cost her €80.00. At the review:

“... They said they had seen no side effects in me, so they gave me Valium\(^{80}\) though, but they said they had seen no side-effects in me ... so I survived the week, they gave me a...

\(^{78}\) Depixol or Flupentixol Decanoate is a thioxanthine analogue of fluphenazine that is used as long acting anti-psychotic medication and is manufactured exclusively by Lundbeck Limited. It is usually administered by deeply intramuscular injection at intervals of 2-4 weeks. The service policy is that it is administered into the Gluteus Maximus muscle. The British National Formulary cites a usual maintenance dose of between 50mgs four weekly and 300mgs every two weeks, noting that individual responses vary and that doses should be titrated to the person’s response. In its action Depixol is not a D\(_2\) specific antagonist rather it blocks a ‘cocktail of compounds’ (Healy, 2009), other neurotransmitters receptors (Dopamine D\(_2\), Noradrenaline, 5-Hydroxy-Tryptamine, Histamine H\(_1\) and Acetyl-Choline) resulting in a wide range of adverse effects that include akathisia or restlessness, Parkinsonian-like side-effects of muscular stiffness and shakiness, abnormal facial movements (tardive dyskinesia), drowsiness, weight gain, interference with a normal sex life and an increased likelihood of developing diabetes type 2. (Silverstone and Turner, 1995; Royal College of Psychiatrists, 2010).

\(^{79}\) Rathmullen Hospital’s acute inpatient unit

\(^{80}\) Valium – the trade name of Diazepam, a benzodiazepine most commonly used in alleviating anxiety states.
bit of Valium, why did they give me Valium? What’s this there? So why did they give me Valium and say they did not see any side-effects?”

Healy (2009:17) contends that antipsychotic medication should not make an individual feel worse, remarking in these instances the dosage is “too high” or the “wrong drug”. Aisling could not understand why she received ‘Valium’. The Depixol ‘Patient Information Leaflet’ has a section labelled ‘OVERDOSE’ in the “Information for the healthcare professional”. It notes specific measures detailing that sedation with benzodiazepines may be required “in the unlikely event of agitation or excitement” (Lundbeck, 2010). Neither doctors nor nurses explained this to Aisling.

The Royal College of Psychiatrists’ website (2010) identifies that where people encounter adverse effects such as stiffness and shaking, they are probably receiving “too high a dose”. It advises users that the medication should “usually be reduced until side-effects disappear”. It further recommends that where people experience adverse effects, but still need higher maintenance doses “these side-effects can be controlled with anticholinergic drugs” such as Procyclidine (Kemadrin).

This was Aisling’s second experience of not being ‘believed’ about adverse effects. Earlier in the fieldwork, six weeks after commencing on Clozapine, Aisling maintained that she was having mini-seizures; on one occasion collapsing whilst holding a cup of hot water. It was a frightening experience for her, which she admitted, effected compliance on her part. Yet, medical and nursing staff greeted her account with scepticism. They felt that her actions were an attempt to break the treatment contract negotiated with her:

“...there was no one who believed, but they didn’t see it, they have to see it to believe it... they didn’t realise how bad it was at the time, so I like, stopped taking it and they were saying keep taking it ... “

I later learned from Regina that it was only after Aisling’s registrar found a journal article reporting an occurrence of absences that staff conceded her experiences might be real. With Aisling’s compliance in question, the consultant decided to discontinue the drug. Aisling interpreted the decision as finally being believed:

“...like they do believe me that I was collapsing there because they do say I can’t go on Clozaril, they say I cannot go on Clozaril and they did believe that I collapsed like... it wasn’t my fault if I am allergic... “

Aisling’s experiences demonstrate an absence of trust by nurses in how people with a diagnosis of schizophrenia engage with medication and in their accounts of adverse effects. The second episode reveals that staff only consider the person’s experience valid when ‘expert’ evidence exists to substantiate the claim. The reinforcement of the pharmacological narrative causes people to think that pharmacy is the only way to resolve problems and difficulties. Accordingly, it results in the lesser consideration of other strategies.

Barfod et al. (2006) consider that physicians can be torn between suspicions of poor compliance and a moral obligation to trust people’s interpretations of their experiences. The dissonance here extends from nurses’ silence, including my own. The ‘silence’ reflecting a lack of security
in nursing knowledge, a reluctance to contradict the established perspective on medication and its use, conflicting opinions held on the benefit of medication or a lack of willingness to challenge psychiatry’s positions. As evidenced in the cases of both Sarah and Aisling, a concern may exist that if the service users’ belief in medication is shaken, no alternative interventions will be available, especially as the nurses in the study were unconvinced of the effectiveness of other alternatives. Here, medication provides them with the most stable platform for their working relationship and in the context of a service already perceived as stretched there is a perception that if medication is undermined, the increased levels of distress experienced by the service users and time and intensity required for their engagement may increase.

Salomon & Hamilton (2012) identify that there is a ‘silence in communication about medication and discontinuation syndromes’. They consider this may be attributable to practitioners’ uncertainty about the information they should disclose when it happens. They feel that ambiguity in the evidence may in part account for nurses’ lack of response. However, Higgins et al (2006) identify that although nurses question the withholding of information about medications, they justify their actions using the ethical principle of beneficence. In the nurses’ view withholding information that may lead to non-compliance is a legitimate response as enhancing medication compliance equates with enhancing mental health and is therefore justifiable. I also used justification in an attempt to reduce my dissonance; my justification in Sarah’s case was that I did not wish to disclose conflicting information in case I undermined her beliefs in medication or challenge her value system about its effectiveness. I did not want to destabilise the status quo of my relationship with Sarah. Equally, I did not wish to have to ‘pick up the pieces’ of doing so, as I could not offer an alternative.

I chose not to undermine Sarah’s belief in medication, and I justified my silence in relation to the perceived lack of effectiveness by reasoning that I did not want to cause trouble within the team. I needed the team’s support and needed to be a part of it. I did not challenge other people’s way of working, lest they would in turn choose to look more closely at mine. I valued the extent of the autonomy I had and did not want to jeopardise it. This was an easy option, as I reasoned that it would be unfair of me to destabilise the status quo of their relationships with the people they worked with, like me; they needed to manage these in the context of their own capacity, knowledge base, time constraints and individual context. I made a reasoned decision, if I did open up a serious discussion I would lose any debate having neither sufficient power in the group or a valid treatment alternative to offer. Thus, I stayed silent, and in doing this, I perpetuated the use of ultimatums and coercive practices.

Coercion and medication

Historically, coercion is a source of ‘longstanding political and ethical concern’ (Anderson 2009). For coercion to exist, there must be a power differential between a ‘coercer’ and ‘coercee’. When people experience difficulty with medication an imperative for ‘compliance’ materialises. The event documented here happened after my withdrawal from the field and is based on my interview with Aisling. It illustrates how needing medication compliance, the service becomes ‘coercive’, represented here in the guise of a ‘coercive proposal’. Kaltiala-Heino et al. (1997:318) identifies that coercion ‘arouses negative feelings’ in people, creating ‘negative expectations’ about treatment and jeopardises the development of trusting relationships with professionals. Following on from the problems identified earlier when Aisling commenced on
Depixol, she remained agitated and irritable, and began getting into arguments with her family. Believing her agitation was attributable to Depixol, she asked to be prescribed Kemadrin\textsuperscript{81} to counteract its effect. When her request was refused Aisling attempted to negotiate a lower dose of Depixol with the consultant.

"I wanted to lower it to twenty five and I was on forty and Dr XXXXXXX. (psychiatric registrar) said that I could, and but then Dr XXXX (consultant psychiatrist) said no ... I could either take the forty Depixol or else stop coming here ... that forty was the therapeutic dose ... it is the forty Depixol or else go and not take anything, and leave the health service"

The choices presented to Aisling can be construed as a 'coercive proposal' (Anderson 2009). Wynn (2006) defines coercion as "the use of force that limits a person's choices, or which involves physical or psychological distress". With both choices, Aisling's distress was clear. A fundamental aspect to the discussion of coercion in schizophrenia rests on the point as to whether coercion is intrinsically wrong. Anderson (2009) identifies three possible standpoints on coercion:

1. Coercion is intrinsically wrong
2. Coercion is ‘prima facie’ or ‘pro tanto’ wrong, but it may be justified by other facts
3. Coercion is intrinsically morally neutral, though some uses of it may be wrongful because of specific facts about them.

An important factor in what constitutes coercion is the discussion on whether coercion should be measured using 'subjective' or 'objective' standards. In this discussion, power inequality between 'coercer' and 'coercee' becomes the basis for the existence of coercion. Manson & O'Neill (2007) believe autonomy is a fundamental value and a property of individuals' independence. However, they argue that individual autonomy cannot be the sole consideration of medical ethics and consider autonomy a 'matter of reasoned reflective choice' (Manson & O'Neill 2007:20). Querying why only set choices should be presented in the use of coercion, they further argue that if 'individual autonomy' is fundamental to ethics, then the only permissible limits to choice should be those required to protect others individual autonomy. Manson & O'Neill (2007) conclude that whilst coercion diminishes the targeted agent's freedom, it is only to a certain extent wrong and/or a violation of right (pro tanto).

Aisling appeared clear on what was happening, and she interpreted the proposal as an ultimatum but did not understand why it was happening:

"I thought that it was a bit rude just to say, to give me an ultimatum ... I don't know what Dr XXXX was trying to do ... it felt like I was being, trying to be pushed away from the service, because I wouldn't take the Depixol..."

\textsuperscript{81} Procyclidine or Kemadrin is an anticholinergic or anti-muscarinic preparation used to decrease acetylcholine activity. More commonly used in Parkinson's Disease, Procyclidine helps control extrapyramidal side effects, such as abnormal face and body movements, restlessness and tremor that occur as an adverse effect of antipsychotic medication.
Aisling refused the forty milligrams of Depixol and attempted to ‘... go and not take anything’. Healy (2006) notes that relapse rates are higher and problems of dependence and withdrawal worse if people suddenly stop antipsychotic medication. The British National Formulary (British Medical Association & Royal Pharmaceutical Society of Great Britain 2001) cautions that withdrawal from antipsychotic medication “requires careful surveillance” even in a person “who appears well”, as they may suffer a “disastrous relapse if treatment is withdrawn inappropriately” (p.173). The nurses on the team did not support Aisling’s choice to stop medication. While she did not believe they would force her to take medication, they constantly reinforced the notion of total compliance, as opposed to a negotiated reduction, or switching to another medication. It was in Aisling’s words what she was “supposed” to do:

“... they would just tell me to take it, you know what I mean, but they didn’t say they would help me to take it, you know ... that was up to me though, I was supposed to take it like, I was supposed to take the medication”

Without help, Aisling struggled over two weeks. In withdrawal she took to bed using her mobile phone as support:

“I was in bed sick, every hour was hell and I thought that I would get through it, I needed phone calls constantly and the phone bill came to €86 in bills in phone calls, so I was making a lot of phone calls”

No longer able to cope with the experience, Aisling relented and recommenced the medication at the prescribed dosage because:

“... I was getting paranoid and I thought my symptoms, my paranoia was coming back ... I felt like my brain just needed to be on medication ... I just felt almost like it did something to me, like messed with my brain, I don’t know if it was just the Depixol, it could have been the withdrawal symptoms from the Depixol ... I never felt so bad in my life, so shaky ... so I took the injection... I agreed to do it”

Feeling that in every week that passes it “drags her down”, with a tone of resignation, she admitted that:

“...it’s just a way of me dealing with things”

Wynn (2006) believes that there is no evidence that coercion works. He believes a significant product of using coercion is the pushing of people away from mental health services and that it results in poorer outcomes. Zito et al. (1985:825) proposes that people who refuse medication and who are not coerced, do not display more ‘threatening, assaultive, or destructive behaviour’, nor do they ‘demonstrate greater noncompliance with other parts of the treatment program’.

For Wynn (2006) the main controversy in mental health is whether the use of coercion is justifiable in cases where a specific danger is not identified. In forwarding a case for the use of coercion in schizophrenia, he highlights the moral imperative to prevent ‘suffering’ and use research evidence, such as evidence on the relationship between increased duration of untreated psychosis and the worsening of a person’s prognosis. Yet, this evidence can be
refuted when placed in the context of long term outcomes with the prolonged use of anti-psychotic medications. Here the debilitating nature of the side effects of both typical and atypical anti-psychotic medication, in the presence of extra pyramidal and iatrogenic weight gain and induced Type 2 Diabetes severely disable those treated. In addition, the supposed benefits from prolonged treatment with medication are not without its critics. Whitaker (2010) contends that prolonged use results in greater levels of disability, more reliance on social services and benefits, and poorer long-term outcomes.

In the discussion of schizophrenia and coercion, the fundamental question of legitimation in coercive behaviour must be answered. Robert Nozick’s 1969 influential paper, “Coercion” opened a new range of philosophical discussion on the topic (Anderson 2009). It established a conceptual framework that delineated conditions for coercion and the work greatly influencing new thinking on the concept. Nozick (1969) argued three conditions for the presence of coercion:

1. Coercion excludes direct use of force or violence, it is only associated with a ‘proposal’ or ‘conditional threat’
2. Coercion is only present if the person yields to it
3. Coercion depends upon the person’s choice, as to whether they take or do not take an action

Under Nozick’s (1969) criteria, if a person does not accede to the threat, then coercion is not present, and the threat only constitutes an attempt at coercion. Lamond (2000) considers the exercise of freedom as central to the discussion of coercion. He also separates coercion from coerciveness, associating coercion with a completed attempt, and coerciveness with attempted coercive behaviour. Similarly, Carr (1988:59) believes that coercion is not at odds with the exercise of freedom, because most cases allow people some form of choice, and if the provision of choice is an essential component of freedom, then this is not ‘antithetical’ to the concept and actions taken out of fear do not diminish voluntariness in the participation action.

Szmukler & Appelbaum (2008) believe there is a growing movement within psychiatry not to perceive cases of forced compliance, like Aisling’s, as ‘coercion’. Rather they believe it should be reframed as ‘treatment pressure’, encouraging reluctant people to engage in care. They categorise persuasion, interpersonal leverage, inducement, and compulsory treatment as holding morally relevant distinctions different to coercion. Mueser et al. (1998) believe that in diagnoses such as schizophrenia’, action is fundamental to assertive treatment, even when a person’s wish to continue in care ‘falterm’, the team must continue to pursue engagement in order to prevent relapse.

If a person’s choices, and arguably Aisling did have a choice, become less appealing to the person does this constitute ‘coercion’? The difficulty in establishing a moral baseline for the application of coercion, as suggested by Wertheimer (1988), is that it creates a problem. Wertheimer (1988) believes it may be impossible to construct a baseline for ‘acceptable coercion’, as numerous possible baselines may exist for judging whether a proposal makes one better or worse off than the baseline. Anderson (2009) argues for the application of a moral
psychological test, as a measure for the appropriateness of coercive intervention. The point of such a standard is that it recognizes that some pressures are excessive. The test identifies a justification for the use of coercion, if in acceding to the coercer's demands the net benefit of the accession to 'coercee' exceeds non-accession. Anderson (2009) concludes that it is unclear that we should conceive coercion is 'intrinsically immoral'; perhaps what is most necessary is to acknowledge its potency, the potential for abuse, and the necessity for thorough ethical scrutiny in each application.

My dissonance in Aisling's situation is vicarious, extending from the action of others. Where medication adherence was questioned, the approaches to Aisling were to resort to 'coercive proposals' effectively pushing Aisling into a state of withdrawal. It was inevitable that a rebound of Aisling's distressing experiences would occur, a consequence that Aisling likely would not endure. The result, Aisling would return and accept what was offered. Nurses in this regard appeared not to support Aisling; they did not argue for her 'weaning off'; they did not explain the likely consequences or attempt to provide other ways of coping. As such, they appear complicit in the use of coercion.

The perceived necessity for coercion in an ordered society establishes a degree of reason in supposing that ethically, coercion depends on a discrete set of factors including 'why and how it is used, who uses it, against whom, in what circumstances, and what other means were possible' (Anderson 2006). Yet, the lessons of Locke (1823 [1689]: Sec. 137) caution us on the investiture of 'absolute arbitrary power' in the control of individual entities, as those with this sovereign power are more subjective and 'through passion or interest, shall miscite or misapply it, cannot so easily be convinced of their mistake ... especially where one is judge, interpreter, and executioner'.

**Dissonance from a failure to get engagement**

All of the events detailed in this chapter, point to the effects of surveillance, control and coercion, and the conflicts they create when nurses seek to maintain personal autonomy. All of the incidents created dissonance for me, principally because my actions or those of the team failed in some way to meet the standard of maintaining primacy of the individual's rights. Perhaps the greatest challenge to autonomy came in the account of Tomás. Tomás tolerated the service's presence but rejected the diagnosis of schizophrenia. Tomás was not interested in engagement or learning more. When I asked him why he did not wish to engage with the service he simply stated:

'... there is nothing there for me'.

A year after the fieldwork finished, I received a phone call from Will, the OT in Glenvilly. Will's phone contact was to tell me that Tomás died by suicide the previous day. Will speculated that in the end, Tomás '...came to a realisation that there was nothing left, that he had 'schizophrenia', and life was no longer worth living'.

I have spent much time reflecting 'what more could I have done?' to get Tomás to engage with the service, but I still have no answer. Some people engage with services through fear, but as

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82 'Rebound psychosis' is a well-documented adverse effect of anti-psychotic medication.
nurses, we also engage with people out of fear, such as fear around the consequences of their actions and the repercussions for both them and us. Nurses too, are the victims of the enshrinement of 'need' transposed into 'risk'. In response, our practice becomes defensive and our reactions at times disproportionate. Despite the reassurances by the consultant psychiatrist and the assistant director of nursing at the introduction to the fieldwork that I would not be alone and what we did in the service was a team decision, I still felt alone. At times, our perception of what is happening makes fools of us all. I still reflect on how my role may have possibly changed outcomes for Tomás, what was to my mind a premature end to a young life. Tomás maintained he took the medication prescribed; but I could never know without the exertion of ultimate control over Tomás’ life whether this was true or whether mine or any other approach could have changed his decision to end his own life. Tomás received latitude in the choice to engage or not. He could use the supports or seek help elsewhere. Was his death by suicide a choice not to do this?

A common thread linking all of the accounts in this chapter relate to 'coercion'. Foucault's concepts of 'creating docile bodies', 'correct training', 'surveillance' and 'control' were all a source of dissonance to me, yet ironically in the strategies I used to reduce the dissonance I felt conflicted on in the use of 'coercion'. On one hand, I was angry when members of the team limited personal autonomy by acting in a coercive manner, yet on the other hand, at times I acted coercively. I used 'coercion' when responding to frustrations, as a tool for engagement, in the hope of making the person 'fit' into the service and to produce conformity in the patient role, so they would engage on our terms. I even punished people to get the pattern of engagement that suited me best. Many of my actions were taken in my role as an 'autonomous' practitioner, using my discretion and power, in part motivated by my need to reduce the dissonance schizophrenia caused me, and in part to fit into the team. In the next chapter, I will explore the nature of the discretion nurses have and the way they use both power and discretion to reduce dissonance.
Chapter 8: Dissonance reduction, the effects of power and the use of discretion

The previous two chapters concentrated upon the sources of dissonance as I experienced them, identifying why and how dissonance occurs and some of the ways I attempted to cope with it. This chapter examines how I tried to cope with the dissonance I experienced. Here, I explore the role of discretion, power and autonomy in the context of the nurse’s role and how they are used in dissonance reduction.

The relationships of autonomy, power and discretion in reducing dissonance

The role that I entered in the fieldwork was that of a clinical nurse specialist (CNS). Bousfield (1997:253) defines this role as a ‘relatively self-directing’ professional role that has ‘considerable clinical autonomy’. According to Weston (2008) there are two types of autonomy, ‘work autonomy’ and ‘clinical autonomy’. ‘Work autonomy’ categorises the actions around “work scheduling, methods, and criteria”, while under ‘clinical autonomy’ nurses have the freedom and autonomy to make decisions about the clinical aspects of patient care engaged in during ‘interdependent practice’ (Weston 2008). Stamps and Piedmonte (1986:60) define autonomy as having “job-related independence”, “initiative” and “freedom” to do what is necessary in daily working life. Following on from the development and use of an individualised interpretation or model of the diagnosis of schizophrenia, in this section of my analysis, I want to explore how varying perspectives on schizophrenia within the multi-disciplinary team dictated the direction of treatment. Key in this regard was the role of nurses’ clinical autonomy, which served to both reduce and create dissonance.

I want to explore the impact of autonomy on dissonance, by linking the concepts of ‘discretion’ and ‘causal power’, to show how these two factors combine, to effect the relationships psychiatric nurses have with people with a diagnosis of schizophrenia. The analysis reveals that in dissonance states, the exercise of autonomy for nurses can become secret and hidden. As presented, the chapter explains first discretion and power in care and then using episodes from the fieldwork it shows how they become interlinked in reducing dissonance. I then show how

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83 The National Council for the Professional Development of Nursing and Midwifery (2001:14) defined a clinical nurse or midwife specialist as a nurse “in clinical practice has undertaken formal recognised post-registration education relevant to his/her area of specialist practice at higher diploma level. Such formal education is underpinned by extensive experience and clinical expertise in the relevant specialist area. The area of specialty is a defined area of nursing or midwifery practice that requires application of specially focused knowledge and skills, which are both in demand and required to improve the quality of client/patient care. This specialist practice will encompass a major clinical focus, which comprises assessment, planning, delivery and evaluation of care given to patients/clients and their families in hospital, community and outpatient settings. The specialist nurse or midwife will work closely with medical and para-medical colleagues and may make alterations in prescribed clinical options along agreed protocol driven guidelines. The specialist nurse or midwife will participate in nursing research and audit and act as a consultant in education and clinical practice to nursing/midwifery colleagues and the wider multidisciplinary team”.

84 Giddens (1984) identifies ‘causal power’ as present when any individual, who through action or inaction in a given situation can influence the outcome or be deployed by others in terms of affecting an action.
the exercise of autonomy becomes a covert exercise in the attempts to cope with professional dissonance.

In a self-directed and autonomous role, discretion becomes an implicit component of action. Dworkin (1978:33) describes discretion as the capacity to decide without consulting others as to the 'sense and fairness' of situations where no explicit standard exists. Evetts (2002) suggests that discretion as a feature is more important to professionals' work than autonomy. She differentiates autonomy from professional discretion, identifying autonomy as complete freedom of action including the capacity to self-regulate, with professional discretion as a more limited form of action relating to workers practices. Murdach (2009:184) identifies five properties of discretion in professional practice:

i. Gives actors scope to decide what constitutes a problem

ii. Allows actors freedom to establish a consensus on possible solutions

iii. Empowers actors to make 'acceptable choices about desired outcomes'

iv. Enables actors to devise and implement strategies to realise specific outcomes.

v. Allows actors to evaluate the progress and effectiveness of outcomes and permission to adjust actions accordingly

In his work, Lipsky (2010) identifies that the use of discretion is a key enabler of street-level bureaucratic functioning. He views discretion as essential, because the work street-level bureaucrats undertake is frequently unpredictable, as the people they work with have wide-ranging and constantly changing needs. Nurses' work with people diagnosed with schizophrenia is a phenomenon of complex and changing needs, a facet attested to by Williams, Bradshaw and Harris (2002), Gamble and Brennan (2006) and Monahan et al. (2008).

Where situations of complex need exist, the imposition of guidelines and controls reduce the capacity of organisations to provide timely responses (Lipsky, 2010). Jones (1992:552) argues that the curtailment of discretion results in "much more mundane and routinized relationships". To avoid such problems, Lipsky theorises that the organisations respond with a system of loose governance, that allows discretion in its professionals' practice, with minimal interference. In particular, he points to the nature of street-level bureaucrats' face-to-face interactions, which happen in private, away from the scrutiny of service managers and other service users. In these interactions, he argues that they "have considerable discretion in determining the nature, amount and quality of benefits and sanctions provided by their agencies" (Lipsky 2010:13).

During this research, I found psychiatric nurses perfectly illustrated Lipsky's (2010) ideas. Psychiatric nurses were the most numerous and most accessible members of the team. They were also the primary providers of knowledge to service users, families and carers about the diagnosis of schizophrenia and its treatment. A remarkable feature of my nine months working with the people on my caseload was that nobody on the multi-disciplinary team questioned the content of my interactions or discussions with people. I observed the same was true of my CNS colleagues during the team meetings each week. Nobody asked me about my beliefs or perspective on schizophrenia either. In addition, at team meetings, I had discretion as to
whether people on my caseload needed discussion by the team, whether they needed a referral to another team member or whether a person needed a medical review. When faced with dissonance relating to schizophrenia, the discretion I had, meant that I could give the person the information I wished. Consequently, use of this discretion allowed me to use my interpretation of the diagnosis and I provided the version of ‘knowledge’ I felt was necessary, effectively this way of acting allowed me to reduce my feelings of dissonance.

With discretion in the face-to-face interactions, nurses, including me, had control over the information they choose to provide or withhold, the following account from Aisling, illustrates this. Over the course of my fieldwork, I regularly heard Aisling ask the nurses questions about schizophrenia and the medication she received. During my interview with her, she recounted how her questions were met with varying responses. These responses were indicative of the individual discretion open to each nurse in the information she gave. Aisling recalled her experiences with Susan, who filled in temporarily as a CNS, when she asked for an explanation of dopamine:

"... well I was asking Susan just there about Dopamine levels and she was saying that with the medication, people have different levels of Dopamine depending upon their illness"

She contrasted this with Shannon’s response, who exercising discretion, avoided the question referring Aisling to the psychiatrist for the answer:

"I was asking Shannon about Dopamine, and she was saying that she didn't know about it, she said that I have to ask the psychiatrist"

McKenna (2003) identifies that nurses’ levels of knowledge can show considerable variability. When nurses exercise discretion in the information and explanations they provide, it can lead to people becoming confused and developing inaccurate beliefs about problems. In her interview, Aisling recalled what happened when she approached Shannon about side effects of akathisia detailed in the previous chapter. Shannon told Aisling that the reason she experienced side effects was:

"...because I could not relax"

It is clear from Shannon’s response that she was deflecting the problem of side effects away from the medication itself onto Aisling and her response to the medication. Following the problems with Clozapine and commencing the medication as detailed earlier, Shannon did not want to undermine treatment with Depixol and risk further conflict over its use. However because of the incomplete information provided, four months after the event, Aisling fully believed that the reason she experienced side effects was that she ‘could not relax’, and it was her fault that she experienced the adverse effect. I asked her why she believed Shannon’s

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85 The rationale for the use of anti-psychotic medication in schizophrenia originates in the work of Carlsson and Lundquist in 1963 who identified that chlorpromazine (an early neuroleptic anti-psychotic) blocked Dopamine receptors in the brain. From this discovery, the Dopamine Hypothesis evolved. Work that is more recent considers that an excess of a neurochemical, Dopamine D2, in the mesolimbic pathways of the brain is associated with the positive symptoms identified in schizophrenia.
explanation; she explained it was because she trusted Shannon by virtue of her seniority and wealth of experience.

Susan's explanations surrounding the use of Depixol did not help Aisling and merely caused confusion. Sometime during their conversations it appeared that Susan commented on the 'mood-elevating effects' of Depixol, leading Aisling to believe that the medication was an anti-depressant. Susan's explanation intensified Aisling's doubts about the accuracy of her diagnosis of schizophrenia. These episodes illustrate that in the exercise of professional discretion nurses acted to divert potential problems that Aisling might present for the team in the future in relation to future non-compliance with medication. Yet in doing so the information provided proved was both misleading and inaccurate, although easing the job of the nurses, it undermined Aisling's knowledge, and increased her reliance and dependence on the service.

"If I was really schizophrenic, then I have been taking the wrong drugs since a while back; like Depixol is working, but like it is like an anti-depressant..."

Nurses' use of professional power and knowledge result in unequal partnerships. Lützen (1998) identifies a complex interweaving of factors in the nurses decision-making process about providing information. These involve their perception of the patient’s competency, the need for strategic action, selective modification and interpretation of nursing autonomy, the justification of coercion and reflection. A further example of the nurse’s use of discretion was in the resources and places to which they referred people. During the fieldwork, nurses only referred people to resources within the service itself. This became clear when Aisling discussed her experiences, when despite hearing voices over a five-year period; she was unaware of support groups for voice hearers both nationally and internationally such as the ‘Hearing Voices Network’ or ‘Hearing Voices Ireland’ (HVI). She was genuinely surprised to hear of the organisations’ existence. Lurie and Shulman (1983:234) believe that self-help groups expand social networks, increase the number of friends and social interactions and that peer-support should be regarded as complementary to the professional role. None of the nurses told her about voluntary organisations or discussed the possibility of using resources outside the service. Despite this, she did not consider blaming nurses for failing to provide this information; she blamed herself for not being proactive:

"...no, you see it is up to me to do those things..."

Solomon and Draine (2001) consider that peer groups bridge gaps in service provision and free up resources enabling other services to be offered that otherwise might not exist. I asked Angela, why the service did not refer people to voluntary organisations such as HVI or Schizophrenia Ireland, to which she replied:

‘...we had some difficulty there, it just didn’t work out’

Field note: Wednesday, Week 13

Even with probing she would not elaborate. Angela’s response and the team’s reluctance for involvement with peer and self-help organisations is a feature documented in the literature. Rubin & Johnson (1982) consider a large number of professionals disregard the role of peer support or self-help organisations as they conflict with their notion of ‘professional’
intervention. Chinman et al (2002) report that while some changes in attitude have happened, the belief among professionals still exists.

**Nurses’ power use and its effect on the outcome of people’s lives**

Power shapes agendas. Dunér and Nordström (2006) identify that the use of discretion and power are linked in the actions of street level bureaucrats. In this section of the analysis, I will focus on the consequences of how psychiatric nurses’ use of discretion influenced the outcome of a person’s life, with a diagnosis of schizophrenia. Over the course of the four episodes detailed below, I will explore how, when faced with dissonance nurses use causal power to reduce dissonance operated in both open and hidden ways. Finally, in the last episode, using reflexive analysis, I will explore how using causal power can itself trigger dissonance.

The diagnosis of schizophrenia exists through the disciplinary power of psychiatry. Psychiatric nurses play significant roles as interpreters of the diagnosis and treatment for service users and their families. Thus in these situations psychiatric nurses can be seen to possess ‘causal power’ (Giddens 1984).

This thesis was part of a larger piece that aimed to explore the role of the psychiatric nurse working with people with a medical diagnosis of ‘schizophrenia’. As designed, it attempted to marry the views of ‘elite interviewees’ (Dexter 1970) to the experience of practice to. I have drawn on a piece of that earlier phase, from the elite interviews, as for me it was pivotal in where the understanding of nurses’ power and the effect it had on peoples’ lives was formed. The following extract came from an interview with Liam, a man diagnosed with ‘schizophrenia’ twenty years previously. Liam describes himself as ‘in recovery’. He continues to experience ‘voice hearing’. Liam recounted his experiences of past care in the UK, where he first had a glimpse of what recovery might be for him. His account illustrates how psychiatric nurses can exercise considerable power and play a central role in the lives of people with a medical diagnosis of schizophrenia:

“...because I know that the nurse that is with me, I wouldn’t have moved anywhere without her because number one she was my protector, number two she was the only one in that whole crazy period that didn’t say I was mad. In fact, she was the only one who said that I was sane, that the system around me was mad and the people who had me here were mad. And society’s role and what brought me to be where I was, was mad, the only sane component within it was me. And, the safety valve that I had was her and the counselling role that she played was vital. The whole piece about empowerment, she came from that. So when she would hear me saying to people I’m schizophrenic, she would go down my throat ‘You are not, don’t ever let me hear you saying you are schizophrenic, you are XXXX (name). You are someone who has had troubles in your life, the same as always but unfortunately you have ended up here, where you should never have been’. You know, so she played that role, the way to describe her and the way I would like to see psychiatric nursing develop was being the holders of hope, because that was the only shade of light that was there, was that one key individual within that crazy time, that had any hope and held on to that hope and tried to move that hope to you on a daily basis. Or at least show it to you and say it is here when you are ready for it, come take it, but I’ll hold it”.

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In this account, the psychiatric nurse involved created an indelible impression on Liam, one that twenty years later he had not forgotten. Giving health advice to address specific concerns that individuals have also constitutes causal power. Silverman et al (1992) identify that service users attach greater significance to the advice given by professionals over more generalised forms of advice. Liam identified the nurse in question as his protector, her actions serving to give him belief and hope. In his account, he portrays her as showing defiance to the system, a system that appears to cause considerable dissonance for her. In coping with this dissonance, she has moved outside of the prevailing perception of Liam and his diagnosis, appearing to establish her own ‘model’ of Liam and his experiences and giving him an interpretation which ultimately he has found acceptable, serving as an impetus to his recovery. By empowering Liam to resist the stigma of the diagnosis and acting as a guardian of hope, she keeps ‘hope’ safe for Liam until he is ready to take on that mantle for himself.

It is not possible to know what the role of Liam’s nurse was within the service or her intentions or relationships with those she worked with. It appears she stepped away from the orthodox psychiatric establishment view of Liam and offered an alternative to the ‘medicalised’ perception of schizophrenia presented by her employers. In her interpretations of Liam and the diagnosis of schizophrenia, she presented a vision of Liam and the diagnosis that would prove more acceptable and more hopeful to him. In her face-to-face interactions with Liam, the nurse acting autonomously was prepared to provide Liam with a view of himself that challenged the medical authority of the schizophrenia diagnosis. In adopting this stance and expressing her beliefs about the system of care and those with whom she worked, she placed herself at odds with those in the system, creating not only the conditions for dissonance to occur but also a dissonance reduction strategy.

Using power to reduce dissonance
Nurses can use power to reduce the dissonance they experience from interactions and events. The following episode illustrates the power individual clinicians can have in influencing the directions of treatment and care. It shows how individual clinician’s perspectives on care dictate the standpoint they adopt and it illustrates how when used, ‘causal power’ acts to reduce dissonance.

The CMHT met each Thursday morning to review the treatment and care of all service users. During team meetings, the consultant psychiatrist encouraged exchanges on current care strategies. In these meetings, the voices of the psychiatric nurses present at the time strongly influenced the decisions made about care. The team made and occasionally overturned decisions, the outcome of decisions dependent on the make-up of the team on the day. In the discussions, different team members expressed differing opinions; individual nurses differed and the presence or absence of one individual could dictate the decision taken.

The best illustration I witnessed of this emerged in relation to Aisling, whose care the team spent long periods discussing over the course of my fieldwork. The most intense debate occurred over Weeks 27 to 30. The key interlocutors in the discussion were Aisling’s consultant; Claire, then CNM of the day hospital; Phyllis, and Brid, who worked with Homecare and Alison

86 Haghighat (2008:549) identifies that people given the diagnosis of schizophrenia prefer ‘certain formulations of the diagnosis over others in relation to their social discourse’.
the team’s clinical psychologist. In the initial discussions Angela, Aisling’s key nurse, was absent on leave only re-joining the team in Week 30.

The twenty-minute discussion on Week 27 of the fieldwork illustrated the standpoints of the team members. In this instance, Claire began the discussion. She reported that Aisling continued to visit the day hospital; she felt she was taking clozapine when supervised in the day hospital, but outside of those hours, she had ‘doubts about compliance’. She questioned the effectiveness of the treatment plan and wondered whether a depot medication would be more appropriate. Phyllis supported her standpoint, questioning was it:

“...worth investing the team’s resources (in Aisling’s care)”

Field note: Thursday, Week 27

Phyllis argued that the team spent a considerable amount of time working with Aisling, between day hospital attendance for medication and additional homecare to supervise medication administration at the weekends. She considered that a:

“...move into rehab, she needs to move on...the community is not an effective residential setting...and she will not agree to a depot”

Field note: Thursday, Week 27

Phyllis wanted to transfer Aisling to the rehabilitation team at Rathmullen Hospital, which offered higher support to long-term service users in supervised hostel accommodation. The Glenvilly CMHT would no longer be responsible for her care. The team’s clinical psychologist pointed out the serious consequences: Aisling would lose her council apartment; her home of two years, for which she had waited almost 2 years on the housing list. She would also lose most of her disability benefits and would need to relocate to a new town. Avoiding the issue of a transfer to the Rehabilitation Service, the consultant psychiatrist shifted the discussion to medication use. He described how as Aisling sought more independence, her compliance with medication fell off and in his view the cycle of relapse began. He argued that the current treatment he prescribed was:

“...the treatment of choice and that treatment needs to go that way, it is not ethical not to use it”

Field note: Thursday, Week 27

Claire continued the discussion stating that Aisling did:

“...not have any understanding of that at all. Would it not be better to let her fail and hospitalise her?”

Field note: Thursday, Week 27

In this instance, Phyllis argued for commencing Aisling on an injectable form of a major anti-psychotic medication. Administered at intervals of one week to one month, these preparations reduce concerns surrounding medication compliance.
Claire argued that whilst on Homecare, Aisling refused medication and was:

‘...doing her own thing, it is a complete waste of time... (since starting on clozapine Aisling) ...is not anymore insightful now than then’

In the ensuing discussion, the team considered possible alternatives for a new care plan, until Brid interjected, commenting on the elements of the proposed plan:

“We have done it ... done it ... done it...has everybody forgotten?”

Brid then recalled how the team had tried each proposed strategy during the previous six months without success; the conversation then returned to the rehabilitation option where Aisling would move into a high support hostel and give up her apartment. Feeling the team spent a considerable time on the matter without being able to reach a decision, the consultant psychiatrist resolved to reconvene the discussion at a later meeting stating:

“If we cannot reach a consensus then the decision will fall to me”

Feld Note: Thursday, Week 27

The team returned to the discussion three weeks later. Angela had returned from leave. Again, people became embroiled in the discussion of non-compliance, resource utilisation and the transfer of Aisling’s care. The consultant psychiatrist appeared to have moved his position closer to transferring Aisling to the Rehabilitation Team’s care when Angela, who had been unusually quiet in the discussion, posed a question:

“But is she not entitled to hopes and dreams, surely she is entitled to that?”

Feld Note: Thursday, Week 30

Angela stated it quietly and calmly. Implicit in the statement was that the team’s actions would deprive Aisling of her hopes and dreams. It was a ‘fateful moment’ in Aisling’s care. Angela made a plea about a fundamental right that profoundly challenged each member of the team. This one question asked so much more of the people sitting around the table. Are we giving up hope? If we do not defend Aisling’s right to hopes and dreams, then who will. Where would you be if your hopes and dreams were suddenly taken away from you? Who gave us the right to take away Aisling’s hopes and dreams? Aisling hoped and dreamed of a place of her own, a job and a relationship. She was making progress with these goals; she had found a place of her own and now the team argued that it should be taken away.

The conversation stopped, nobody spoke. It appeared Angela’s comment evoked dissonance for all in the room. The silence seemed to last an age. Aisling kept returning to the service, hoping it could lessen the burden she endured. The service struggled to find an answer. The statement struck a chord with every person in the room. The story spoke to the failure of nurses on the team to create a relationship that could help Aisling and in their inability to find a

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88 Giddens (1991) explains that people can be confronted by ‘fateful moments’; crossroads when they know that decisions must be made that require them to embark on a new path, to make a decision that will be very difficult or cannot be reversed.
successful outcome in the short term. We see dissonance in the team members, manifest as a need to reduce the dissonance they might experience from this inability to find a resolution to Aisling’s problems. In the team’s ‘failure’, we see the crystallisation for the use of mechanisms of control which will ultimately deprive a person of her agency in decisions relating to independent living. The initial actions of the consultant psychiatrist speak to the implications of the decision to deprive Aisling of the ‘treatment of choice’. In the challenge of allowing Aisling to ‘fail’, Aisling suffers; it is the team that fail her.

Removing Aisling from regular view to another part of the service perhaps offers a solution to dissonance, almost a case of ‘out of sight out of mind’. The ‘question’ when posed altered the direction of care. Eventually the consultant opened the next case file and moved on. The team did not consider Aisling’s possible transfer to the rehabilitation team again and made no changes to her treatment plan for the next four months.

The incident points to how members of the community mental health team struggle to fulfil their social control mandate. Team members’ values, beliefs and perceptions of people given the diagnosis of schizophrenia governed the actions of the protagonists in this discussion. The catalyst for Angela’s actions in the defence of Aisling appears to be the professional dissonance brought about by the other team member’s conflicting perspectives and beliefs on the agency of Aisling, as a person given a diagnosis of schizophrenia. By making her plea and challenging the values on which the other team members formulated their decisions, Angela’s actions rightly or wrongly influenced the outcome for Aisling; an example of Giddens’ ‘causal power’ in action.

Angela’s actions pose a question as to whether she might experience greater levels of dissonance in relation to Aisling’s care than other members of the team. One possible factor may be the role of education and social status that Snibbe & Markus (2005) identify. When we examine the nurses in the debate on Aisling’s care, Claire and Angela, differing education choices emerge. Both worked in the same psychiatric hospital around the same time and followed roughly similar work pathways. Both joined the team in Glenvilly around the same time and attained the same grading within the service; Claire, as Clinical Nurse Manager Grade 2, and Angela, as a Clinical Nurse Specialist, graded at the same CNM2 level.

Where they differed most was in the type of further education they chose. Claire completed a Masters in management. Angela’s clinical nurse specialist role required her to undertake a diploma in specialist nursing and she completed a post-graduate higher diploma in enduring mental health problems. The programme was designed for nurses to promote advocacy in roles, and negotiate and represent the client’s values, needs and wishes in collaboration with other professionals and community resource providers. In doing this, the programme espoused a long-term commitment to service delivery based on the concept of ‘recovery’, with psychotherapeutic interventions for persons with severe and enduring mental illness underpinning approaches to care. Angela’s education programme created ideals for the care of people with a medical diagnosis of schizophrenia that may have led to greater dissonance requiring Angela to act to reduce it. Although not definitive, the outcome of these educational choices offers an interesting perspective on the individual responses to people with a medical diagnosis of schizophrenia.
Reducing dissonance – Getting the outcome ‘I’ wanted

Moss Kanter (1988:71), in writing on sociological inquiry, emphasises that researchers making sociological interpretations should be sceptical ‘about the true purposes served by what appear to be harmonious social relations’ and that ‘someone must be manipulating the situation in his or her own interests’. She continues by challenging researchers to establish who this is. A way that a practitioner can reduce professional dissonance is by obtaining ‘his/her own’ preferred solution in a situation. Lipsky (2010:169) argues that this is facilitated by a phenomenon of street-level bureaucracy, where individual bureaucrats in their face-to-face interactions, work ‘in private’ and ‘beyond the scrutiny of supervisors’. Consequently, he believes we cannot truly know the content of interaction and motivations for action. Here, the autoethnographic approach allows some insights into the reasons for my actions.

Getting the outcome you want reduces dissonance. The following account comes from my interactions with Andrezej. It analyses a medical review conducted by the psychiatric registrar in Week 44 of the fieldwork. In the lead up to this review, Andrezej missed two scheduled appointments at the outpatient clinic and the consultant decided to enforce the non-attendance policy and discharged Andrezej. I argued at the team meeting for Andrezej to have another chance. I explained Andrezej was under considerable pressure caring for his younger siblings as his parents had appeared to return home to Poland, leaving him in loco parentis. The consultant agreed and I asked the registrar to see Andrezej at the emergency clinic on the Friday afternoon. These medical reviews involved usually the psychiatric registrar or consultant and the relevant CNS.

Before the meeting, I provided the registrar information on events over the previous two weeks. I approached the meeting wanting Andrezej to take ownership of managing his ‘voices’ and let him identify his needs on medication. I pressed for the review as on my last visit to Andrezej’s house, I found him struggling to look after his younger siblings and brother with his parents away. He complained about his difficulty sleeping, how he struggled with medication compliance. The prescribed medication, he complained left him drowsy, unable to get out of bed. He admitted when he was drowsy he stopped taking medication. Having run out of medication the previous week, he was unable to sleep as the voices droned away and they made him fear for his safety. Andrezej and I discussed a plan for the review at the house during my last visit with him; we agreed a strategy for the meeting. His believing that the dose was too high and that he might cope better with a lower dose, the plan was that he would recount his experiences, his drowsiness, and ask to get the dose lowered. I would support him in the request.

Porter (1991) states that nurses openly try to influence decisions in clinical practice. Historically, the long held view was that the doctor’s position as clinician was one of unchallenged knowledge and dominance, and using the ‘doctor-nurse game’ nurses try to inform and advise the doctor without challenging his/her position (Stein 1967). According to the rules of the ‘game’ nurses were according to McMahan et al. (1994) powerless and unable to directly influence decisions, and needing to resort to manipulation. However, Svensson (1996:381) considers that nurses’ roles have changed since the 1980’s and nurses now have an increased role not just in daily interactions but also in ‘defining the patients’ medical status’. This changing role for nursing, he sees as evolving from medicine’s increasing need to manage ‘chronic illnesses’ that need greater social dimensions in care; that nursing can provide a
different type of care, more appropriate the need to ‘handle life’ and not ‘prevent death’. This has resulted in a shifting in the power dynamic.

I brought Andrezej into the consulting room; initially the registrar sat reading the case notes, two minutes passed. Andrezej looked to me, uneasy at the delay. The registrar asked Andrezej:

Registrar: ‘How have things been?’

Andrezej: ‘Ok (he paused)... I need tablets’

The registrar proceeded to run through the process of ascertaining the presence or absence of symptoms. Andrezej denied hearing voices or other psychotic features and when asked if there were ‘...any problems at home’ he said ‘no’ also denying ‘...any other problems’.

As the review progressed, my discomfort grew. Andrezej’s answers puzzled me; I could feel my frustration building. He provided a completely different account of events from the previous meeting. It completely contradicted the briefing I gave the registrar before the meeting. I felt compelled to intervene. I interjected:

‘You said you were having difficulty during the week, you said the medication was making you very drowsy and you could not cope, so you stopped taking the meds’.

He nodded in agreement.

‘You said you were hearing voices’.

Again, he nodded in agreement. I then introduced how Andrezej was caring for his sisters and brother, whilst his parents were away and how this stressed him and made it difficult to cope. He did not acknowledge this or comment. I switched the conversation to Andrezej’s care plan; how he did not adhere to the agreement that he made with the service. When I spoke to the registrar prior to the meeting I told him, ‘I’ wished to reinforce the terms of that agreement and ‘I’ wanted to emphasise to Andrezej that the service was not just for medication. Andrezej could not ‘dip in and out’ of the service; it was a package and engagement with ‘me’ as his key nurse was central. If he wished to remain with the service these were the terms, otherwise he needed to arrange care elsewhere. At the end of the meeting, the registrar decided not to reduce the medication; maintaining the same dose, he revised the prescription to a slower release version.

I left the meeting feeling that I had not achieved my objective. My intent in including this episode is not to show the effectiveness of my attempts to manipulate both Andrezej and the registrar, but to illustrate what the intentions of my actions were.

The event proved to be critical in my understandings of what ‘I’ was doing in my relationships with people with a diagnosis of schizophrenia and the people who were a part of the system providing care. Reflecting on the event, I believe Andrezej was intimidated; he did not wish to place his family in a vulnerable position and possibly jeopardise their social welfare benefits by admitting to an ‘authority figure’ they were not in the country.

During the review, I reasoned that I acted in Andrezej’s interests. Although I believed this at the time, it does not adequately explain my actions. Reflecting on the account, when Andrezej did not adhere to the ‘pre-arranged script’, I cut across him and ‘rectified’ the account. I realise
that I did this not as a paternalistic gesture acting in Andrezej’s best interest but so that ‘I’ would appear right, so the account would fit with ‘my’ version of events and ‘I’ would not look like a fool in front of my medical colleague. What happened was an exercise of power in a clinical interaction; I attempted to impose my interpretation of the situation using my system of values and beliefs and my understanding of the diagnosis of schizophrenia. I am conscious that in this situation, I was giving my version of events to and was imposing my interpretations of what was happening. I tried to control the interaction; the meeting became ‘my agenda’; it was I who set the agenda for the review, not Andrezej or the registrar. The content was what I wanted to discuss, similar to our regular meetings, where I made the choice to emphasise a ‘normalising’ perspective rather than a biomedical one, I dictated what Andrezej should know about ‘his’ schizophrenia, as opposed to letting him dictate what knowledge he required. In the course of their role, psychiatric nurses reproduce activities that recreate a need for psychiatric nursing and justify the need for their presence. With my actions I attempted to justify the need for my own role.

Psychiatric nurses selectively control decision-making information according to their own perceptions of schizophrenia, their interpretation of the person’s needs, the needs of their job and their need to remain credible within the team. The episode shows an attempt to engineer a situation to create the outcome I desired. I experienced dissonance from two perspectives, i) dissonance resulting from what I perceived to be inappropriate treatment and ii) from Andrezej’s failure to engage. My attempt to reduce dissonance was not just trying to manipulate the registrar and influence his prescribing decision; I was also attempting to manipulate Andrezej.

At this point, I queried whether I had become a ‘Snake Oil salesman’. ‘Snake Oil’ is a traditional Chinese remedy used to treat arthritis and joint pains. As its popularity grew, access to the raw materials to produce the product diminished and in the absence of regulation, travelling ‘doctors’ attempted to reproduce the formula using their own ingredients. Lacking the key ingredient from the Chinese water snake, these products lacked the efficacy of the original, and over time with dubious marketing strategies, the term is ‘snake oil’ became a derogatory label for peddling ‘quack’ cures. I now questioned whether this had happened to me. In utilising my own model, and proffering the approaches I believed were most appropriate for the individual, I had become the ‘snake oil’ salesman.

In this situation and in the event to follow, in the next section of analysis, we can see how psychiatric nurses can prime decision-making forums, such as out-patient consultations with registrars, to influence treatment plans in the direction they feel is most appropriate. They draw attention to problems and attempt to get the outcomes that they think are best. Here they deliver information to psychiatrists based on their perceptions, their own values and assumptions. In relation to Andrezej, my interpretation of schizophrenia governed the information I gave. By doing this, I sought to reinforce the belief that ‘my way’ of working within the service in relation to schizophrenia was right and thereby reduce the dissonance I

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80 Snake Oil is an extraction from the Chinese Water Snake and used topically acts as an analgesic. During the expansion of the railroad in the United States during the 19th century, its reputation grew as Westerners witnessed its ‘miraculous’ effect on the aching joints of the Chinese labourers and snake oil developed a reputation as a panacea.
experienced with the system of care where I worked. Yet in doing so, with my ‘pluralistic/eclectic’ interpretation, I was no different from any other person offering a perspective; imposing a paternalistic view of what I saw as the ‘right’ version of schizophrenia.

The ‘final scene’: coping with dissonance
Nurses’ perceptions of people’s potential to succeed in life, frame the encounters they have. The orientation of a psychiatric nurse to the diagnosis of schizophrenia and his/her personal beliefs about the person influence the outcome of care. Where questions arise relating to social control, the belief and value system of the psychiatric nurse that the service user encounters can have enduring effects. Occasionally, situations arise when a person’s key worker or key nurse is not present to deal with a situation. When these situations occur, other staff members, possibly with different orientations to schizophrenia, may deal with the person. The difficulty is that they may operate from different perceptions of the problem and perhaps from different value systems in relation to the diagnosis. The outcomes of the subsequent interactions and interventions may be in conflict with the intentions of the key worker or may undermine courses of treatment. In severe cases relationships may be sabotaged, with the result that the person’s disengages from the service. In such instances, vicarious dissonance can result from the different course of action that can follow. The ensuing account details one such episode and the cycle of events triggered as a result.

The analysis centres on an episode that occurred late in the fieldwork, during weeks 46, involving Claire, who was then CNM2 with the homecare team and Greg, who as detailed earlier, received a diagnosis of paranoid schizophrenia. The episode concerns coping with dissonance surrounding choices in medication use, and in particular the role that individual nurses play in decision-making on care. Central to the discussion was the consultant psychiatrist’s prescription of the anti-psychotic medication, Quetiapine. As a prologue, the account details the happenings leading up to the event, to add context, I was Greg’s key nurse, and Claire worked with Greg previously in both the Day Hospital and to a lesser extent on the homecare team.

Greg was unhappy with Quetiapine and he discussed discontinuing the medication with his psychiatric registrar. The team believed Greg’s strange thoughts did not improve while prescribed Quetiapine and that he remained distressed by them. The consultant wanted to prescribe Clozapine, but Greg was unwilling to accept it. This was a decision that the service disagreed with and ordinarily did not recommend. With the agreement of the consultant psychiatrist, Greg’s dosage was titrated downwards over a two-month period. When Greg

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90 Greg believed there was a conspiracy, and as a result, he would die at a pre-appointed time.
91 Categorised as one of the newer atypical anti-psychotic medications, Quetiapine (Seroquel) is a drug with a controversial history. In its ‘Summary of Product Characteristics’, AstraZeneca Pharmaceuticals recommend that the dose of Quetiapine ‘may be adjusted within the range 150 to 750 mg/day’. Following a class action suit taken in the United States by service users prescribed the medication, court documents showed that its manufacturers AstraZeneca were aware of potentially serious side effects in 1997, three years prior to its approval by the FDA in the US. They showed the company attempted to conceal these potentially hazardous side effects relating to weight gain and diabetes. One particular 1997 clinical trial, ‘Study 15’ gained particular notoriety. The study showed significantly higher rates of relapse when compared to conventional anti-psychotic medication, with inability to tolerate the medication regime at doses below 700mgs identified as particularly significant.
decided he wanted to discontinue Quetiapine, his consultant transferred his care from the homecare team to clinical nurse specialist team, and I became Greg's key nurse. The consultant decided that a member of the team should contact Greg's sister and advise her of Greg's decision to gradually discontinue his medication\textsuperscript{92}. Now Greg's key nurse, I was directed to make contact and advise her that if she had any suspicions or concerns she should arrange to have Greg admitted to the acute admission unit as a non-voluntary patient. The consultant also referred Greg to the team's clinical psychologist for assessment and I liaised with her regarding developing a cognitive intervention strategy.

The clinical psychologist considered Greg a very rational and pragmatic person. In her evaluation, she believed that the most beneficial approach would be to increase the level of trust Greg had working with the team and concentrate on reducing the amount of distress his beliefs caused. In a collaborative approach, we embarked on a strategy of 'thought mapping' and 'thought experiments' using the Greenberger and Padesky (1995) 'hot-cross bun method' for use in psychosis (Morrison 2002)\textsuperscript{93}. After six weeks working in that manner, we believed Greg was beginning to differentiate between strange thoughts and real ones and he began to question the basis for his strange beliefs. The psychologist and I tried to get Greg to be more open about his experiences, in the hope he would be able to come to terms with them. We took a view that Greg's thinking about the conspiracy was ingrained and did not constitute a cause for the team to act. He managed with his thoughts, they were present a long time and he had not acted on the threats, such as self-mutilation.

After Greg's registrar reduced the medication to Quetiapine 100mgs, at the team meeting I reported that in my most recent encounter that Greg remained distressed and although the day on which he expected to die had passed when I asked Greg what the 'conspiracy' might hold for him next Greg replied that he thought it might involve 'hearing voices'. He was curious to know what this experience might be like. This raised suspicions in the team that Greg was already hearing voices, although Greg denied this\textsuperscript{94}. Claire stated she believed this was already the case; however, the consultant believed this was insufficient grounds to admit Greg in a non-voluntary capacity to the acute admission unit in Meadowfield.

I met with Greg the following week; he acknowledged that since reducing the medication to Quetiapine 100mgs, he was experiencing more distress. I asked him to reflect back to when he was on the 200mg dose and whether he had coped better, he said he could notice a difference and agreed it would be worthwhile to increase the dose back to 200mgs. The clinical psychologist considered that this was a significant event and demonstrated considerable trust on Greg's part in the working relationship that we had established. He had acknowledged a

\textsuperscript{92} Ordinarily, staff did not directly engage with relatives without seeking the person's permission and outlining the content they would disclose. This was one of only two circumstances where I saw staff directed to break this rule. In both instances it related to decisions to discontinue under medical supervision. In Greg's case, he was not informed of the decision or the direction that I was to give his sister.

\textsuperscript{93} Morrison's model operates using cognitions, physiology, behaviour and emotions as a method for analysing thoughts and beliefs in an attempt to develop insight.

\textsuperscript{94} In an ironic twist, this is the exact scenario of Festinger's work 'When prophecy fails'. When faced with the reality that the foretold apocalypse did not manifest, the cult members sought an alternative form of explanation.
relationship between his thoughts and his distress and accepted responsibility for the decision to utilise medication as a way of coping.

Two weeks later, Greg's sister brought him to the clinic for review. When I visited Greg five days previous, he felt his level of distress had improved following the increase in medication, he was not hearing voices or considering doing harm to himself. In an unusual set of circumstances, neither the clinical psychologist nor I were present on the day Greg came to the clinic with his sister. I was on a day off; the clinical psychologist was at her monthly clinical supervision meeting. Claire met Greg and his sister. She recounted the episode the day after the event. Greg's sister was still concerned that he was growing more distressed by his thoughts. She spoke with Claire, who had the medical registrar review Greg. Claire also sat in on the interview. After the interview, Claire recounted that Greg said very little and she thought that Greg should talk to the consultant.

She described the outcome of the meeting; the consultant psychiatrist offered Greg a choice. Although Greg had previously agreed to increase the amount of Quetiapine he took from 100mgs to 200mgs, the consultant insisted that Greg recommence Quetiapine 700mg under supervision. He was also to attend the day hospital Monday to Friday for medication and have medication administered by the homecare team at weekends. If he did not, the consultant advised Greg that he would admit him as a non-voluntary patient to the acute admission unit at Rathmullen. Greg relented; he returned to the care of the homecare team and agreed to the administration of Quetiapine at home under supervision.

I spoke with Claire as to why she thought this course of events had unfolded in the manner they had. She stated she felt psychological interventions in schizophrenia were "useless", especially where risk was concerned. She said she believed that Greg had a very serious mental problem, that he was psychotic and that his behaviour represented a risk.

Claire's actions appeared to be based on an assessment of what Greg was capable of doing under the influence of delusions, which she believed might materialise. In the conversation that followed Claire argued that in situations like Greg's, where people refused medication, confrontation and if necessary coercion were acceptable responses. She believed that pharmacological intervention was necessary and where people resisted it, non-voluntary admission was appropriate. Claire believed that Greg needed more medication. She was also clear on what she felt she needed to do. Following the registrar's decision not to act, Claire brought Greg to see the consultant psychiatrist. Claire stated she knew the consultant would be prepared to:

'...tackle the problem [because] ... I know XXXX (consultant psychiatrist's first name) he will make decisions, there are no problems; he doesn't mess about''

Field note: Wednesday, Week 46

I have included this event, not because of the content of accounts used to make the decision, but in the intent of nurses to intervene to get the outcome that they perceive as necessary. When I discussed the episode with the clinical psychologist, we believed we would have handled the situation differently. We would have told Greg's sister the intention of our work, explaining
how Greg was developing a degree of insight into his ‘memories’, and starting to challenge the validity of his beliefs. We would have explained how we thought confrontation would jeopardise the relationship with the service causing Greg to disengage and no longer trust staff if he was coerced. We were of the view that given Greg’s success with the negotiation around medications previously we may have convinced Greg to increase his medication for a short period of time. Greg had proved amenable to this approach in the past when presented with ‘rational’ explanations, and involved in the decision making process.

If we consider Claire’s statement, in her decision to bring Greg to the consultant, in ‘knowing’ him, she had anticipated the outcome. If the consultant was not going to ‘mess about’, then by implication she believed that ‘others’ were. Knowing how the consultant would respond, the implication was that she knew what the outcome of her actions would be. It appears that Claire’s internalised ‘model’ reasoned that coercion and confrontation were an appropriate solution to the set of circumstances she saw. Perceiving a lack of effectiveness with psychological intervention and convinced of the necessity of medication, these beliefs and values dictated that she should present Greg’s situation in a particular way to the consultant in order to get the outcome she felt was needed.

Gerrish (2000) identifies that nurses deliberately manipulate situations when people resist what they consider the best course of action. She believes that nurses rationalise these actions using paternalistic concern for the patient’s safety. In her decision to take the case to the consultant by her own admission, Claire expected the outcome of coercive action and forced compliance, options, which she believed, were legitimate courses of action. Svensson (1996) identifies that nurses’ roles are now stronger in clinical practice and they have increasingly become controllers of medical work. Claire believed that Greg’s behaviour constituted a risk, that psychological interventions were ineffective, and medication was required. Her internalised model of schizophrenia and her beliefs in what was needed dictated the course of action. When I discussed the matter with the consultant psychiatrist in the car park on the Friday evening three days later; he saw a simple explanation for the action:

"I will tell you exactly, clinical circumstances took precedent ... (he continued) I am not really sure if there is a role for psychology in psychosis"

Field note: Friday, Week 47

This perspective does not correspond with the findings of established research on the use of cognitive behaviour therapy, now incorporated as a fundamental component of care in guidelines such as those of the National Institute of Clinical Excellence (2009), which advocate a broad-based approach encompassing pharmacological, psychological, social and family interventions as the most appropriate way to manage the diagnosis. The two months’ work spent by the psychologist and me developing Greg’s trust were lost. Greg never returned to the clinical psychologist to explore the use of cognitive interventions further.

Professionals need is to be able to tolerate the content of strange thoughts and voice hearing; people who experience these phenomena rarely talk about them and do not share the problem, as they get frightened away from professionals, afraid of the consequences of doing so (Romme & Escher 2000). Equally, service providers avoid exploring these thoughts. When working with
people who hear voices and experience strange thoughts, nurses need to be able to cope with the content of these thoughts rather than perceiving them as 'risks' that require action. This perception is a significant barrier to working with people cognitively, as nurses are conditioned to act as opposed to developing an ability to tolerate 'therapeutic' risk. Graham (2006:43) argues that when nurses identify service user needs the 'professional' mental health system 'covertly' translate and transform them into risk. Nurses need to be able to differentiate between what constitutes an essential cause to act and long standing strange thoughts. Failure to do this will result in a perception that a person is flawed, and will be 'progressively deprived of human rights' (Clarke 2003:139). It appears that Claire's need to reduce dissonance resulting from the impression that Greg was at risk, his sister's desire for action and her view of the diagnosis of schizophrenia were the impetus for her to act. The problems of dissonance arousal lie in nurses' inability to trust service users and to dispel innate insecurities about risk.

The outcome of this episode raises an interesting question; why did I experience such high levels of dissonance by comparison with colleagues, who held similar views about the diagnosis of schizophrenia? The cultural background of people appears significant when trying to understand the dissonance they experience. So why did my dissonance require that I take action? Nursing within the community mental health team predominately functions as a 'holistic' culture. It is heavily reliant upon shared disciplinary knowledge and interdependent relationships with other disciplines such as medicine and psychology, and thus the need to retain harmony in interpersonal relationships is a major driving force. Sharing holistically oriented values, as part of the community mental health team, places potentially 'dissonant' members in the position of maintaining harmony so that dissonance does not emerge. When a potential conflict emerges, the nurse prioritises harmony, the experience of dissonance does not occur and there is no need for action.

My move to the academic environment ten years ago brought with it a change in the way I thought about the subject of schizophrenia. The way in which I think and act has changed, and the values underpinning my actions have shifted from a 'holistic' culture to an environment deeply invested in 'agentic' culture, the university. In this environment, I became a lecturer espousing both psychological and social approaches to working with people with enduring mental health problems. As a lecturer I am expected to speak with authority on the subjects I teach. People expect that I say what I believe is right and believe what I say. Subsequently my fieldwork placed me within the constraints of a team where prevailing values and beliefs ran contrary to mine, and created the conditions for dissonance to grow. Yet, I was not the only person to experience dissonance in this area, it appeared Angela did too. As a clinical nurse specialist with specialised knowledge, discretion and autonomy in face-to-face interactions with people, she was in a post that emphasised increased responsibility for actions. For Snibbe & Markus (2005), increased autonomy coupled with increased knowledge creates an 'agentic' force, increasing dissonance and the need to act. In this situation, where there is no immediate way to reduce dissonance, individuals begin to work with their own model of the individual and diagnosis and use the practices they believe in the best interest of that person. However, in their face-to-face interaction, by exercising autonomy and acting in secret they become 'silent
saboteurs’, potentially undermining or sabotaging the decisions of others on care (Warelow 1996).

**The ‘final recourse’: Withdrawing from the field**

In Delamont’s (2005) essay on leaving the field, she points to most researchers failing to account for the decision to terminate the fieldwork. Researchers need to stay in the field long enough to experience participation, but not too long. Drawing upon Don Mannix’s (Mannix 1951) work on carnival life, she considers ethnographers are rarely lucky enough to meet a ‘fat lady’ who warns of the peril of going ‘native’.

> “Daisy warns Dan that the longer he spends with the carnival ‘the more of a freak you will get, until pretty soon you can’t be happy anywhere but in a carny, where there’re other freaks for you to be with’”

As in Fine (1993), sometimes it is the recognition of ‘going native’ that precipitates the decision to leave the field. In his research on ‘dungeons and dragons’ groups, his realisation was that as each week passed, he felt he became more powerful in the group and central to its functioning, acting as mentor to the younger members. Increasingly, it became impossible for him to take a minor role and observe; he reached a point that he describes as “diminishing analytic returns”; when a researcher needs to look for a point where nothing can be learnt, this is indicative that they have ‘gone native’.

At times, the research’s impact on the researcher, draining energy, can be symptomatic of the researcher’s over-involvement. This was my experience. Two events in week 46 led to my questioning my role in the field. This first happened on the Wednesday morning during the outpatient clinic. On reaching a point of total frustration with a service user diagnosed with borderline personality disorder, I returned to the meeting room expressing my frustration. As I sat down, I cursed. Angela smiled, ‘finally...’ she said, ‘...it has taken a long time, now you are one of us, and I wondered if I was ever going to see it, you realise that’s the first time in nearly a year that you have had a bad word to say...’; she laughed. I felt my professional persona had slipped.

The following Friday marked the second episode, with Greg detailed earlier. The episode of forcing Greg to recommence high dose neuroleptic medication proved a ‘fateful moment’ in the fieldwork. It culminated in a loss of trust between Greg and the service, and the unravelling of three months’ work spent establishing a strong relationship with Greg. I discussed the episode with the consultant in the car park on the Friday evening. He adopted a standpoint that the action was justified; I interpreted that he did not see a role for psychological intervention in psychosis.

The overt use of coercion, the destruction of the work by both the psychologist and me who were trying to build insight and the declaration by the consultant that there was no place for psychological intervention in psychosis increased the level of dissonance I experienced. Reflecting on the event, I felt I had three alternatives. I could accept the team’s way of working with people diagnosed with schizophrenia, compromising my own beliefs and value system and becoming fully party to the approach. I could resist the team’s way of working, becoming not just a ‘silent saboteur’ but overtly questioning the team’s actions and ways of working. The
dissonance equation had reached a point where the greater the level of arousal the greater became a call to arms for action. In tandem with this, the foreseeability of the negative consequences, which resulted from the coercion of Greg, became more real. Shortcomings in my own behaviour became more evident and intolerable: the greater the magnitude of dissonance, the greater the need for dissonance reduction became. I decided that irrespective of my needs, I could no longer tolerate the inability to provide choice in treatment; I decided that I was prepared to engage in conflict on the matter. I spent the weekend considering the way I would act when I returned on the following Monday.

As I reflected on the manner of my attitude over the previous weeks, I found I was expressing my views more freely and more forcefully. I was prepared to challenge other members of the team more openly. I realised that in reaching this point, in an ethnographic sense, I had gone 'native' (Malinowski, 1922). My preparedness to challenge actively with the dilemmas I faced in clinical practice, demonstrated to me that I was no longer concerned with the purpose of my research, but with my engagement with the team and care. I could no longer try to seek justifications; I was not reliant on staying silent to keep my 'job' as others may have had as justification. I still had a 'job' elsewhere and was therefore 'freer' than others that might be so affected.

I had come to research not to become a destructive influence within the team. Faced with that realization, I decided to choose the final option; I should finish the data collection prematurely and leave the field. If I could not find an outlet, I had to walk away because I could no longer cope. This was the final recourse in dealing with dissonance. Like Altheide (1980:307-8) in his decision to terminate fieldwork, I too found that I had become more confrontational. The realization dawned. It was not my position to confront the team or undermine the treatment of those in the service. I wondered what the result would be for those left in care or for those in the caring role. This was a team that was working in a difficult context. If I opened up a debate on the team’s approaches to care, I might jeopardise existing relationships, creating problems that might be difficult to resolve in the time I had left. I had intended to walk away from the field two months later. I came to the field as a researcher and observer, not to become a destructive force within the community mental health team and then walk away. I had ‘gone native’; my emotions and the perception of the ‘right treatment’ had taken over and my delivery of care took precedent over my research. I concluded that I had achieved data saturation; there was nothing new that I felt I could learn from the field. I discussed the decision with my supervisors and on the Monday morning, I told the team that I needed to return to college and would end the data collection in three weeks. I made plans to return the people in my care to their designated ‘key workers’. I left the field at the end of fifty weeks data collection.

The end of this analysis shows the consequences of a psychiatric nurse’s attempt to cope or ultimately fail to cope with the dissonance that the medical diagnosis of schizophrenia causes. In attempting to do this, it reveals the fallibility of the human condition, which despite the best of intentions at times places the interest of self and the functioning of the service before those of the person in distress. When attempting to struggle with the ambiguities that the diagnosis causes, the clash of values and beliefs led me to act on my own formulations of the diagnosis, using discretion in what I told and withheld. It became an exercise in using power, done with autonomy and when not secure in my own identity, done covertly and secretly. It became a
struggle in coping, finally leading to a dilemma as to what was more important, my own personal agenda or the integrity of a team endeavouring to help people in distress. What follows in the next section is a brief synopsis of peoples’ progression since the end of the fieldwork, classed as an ‘epilogue’, and a final chapter detailing the conclusions I have drawn at the end of study.

The Fieldwork Epilogue

A year and a half after I concluded the fieldwork I followed up some of the people who I met in the course of my journey, where they were and what happened in the intervening period.

Sarah

Sarah’s life materially did not change after I left the service. The responsibility for her nursing care reverted to her original keyworker. Sarah continued in her own pattern of life with its inherent ups and downs, continuing to reside in the family home with her parents, using the service as the central component of her social life and continuing to adhere to the medications prescribed for her.

Greg

Greg continued to attend the service for medication. Staff remained sceptical about his compliance. He found a job working in computers. When last I heard he had not returned to the clinical psychologist to work on understanding his thoughts. His keyworker described him as ambivalent about the service’s involvement.

Andrezej

After his discharge from the service Andrezej was sent to prison. I was told the prison service contacted the team seeking advice on treatment with a depot anti-psychotic medication, a treatment that in the community Andrezej refused.

Holmes and Rahe in their ‘Life Events Scale’ (1967) identify imprisonment as a highly significant cause of stress. An increase in paranoid ideation might be a ‘reasoned’ response. Also, long periods of time spent in isolation are known to cause ‘voice hearing’ in healthy subjects (Bentall 2003). I thought that these stressors might lead to an increase in ‘voice hearing’, without the added complication of a first time offender from an ethnic minority. I wondered how Andrezej might respond to a proposal or a likely exacerbation of his experiences. The provisions of the Criminal Law Insanity Act (2006a) Section 15(2) stipulate in circumstances:

‘...where 2 or more relevant officers certify in writing that a prisoner is suffering from a mental disorder for which he or she cannot be afforded appropriate care or treatment within the prison in which the prisoner is detained, then the Governor of the prison may direct in writing the transfer of the prisoner to any designated centre for the purpose of the prisoner receiving care or treatment for the mental disorder notwithstanding that the prisoner is unwilling or unable to voluntarily consent to the transfer’.

The practicality of this provision effectively permits Governors to transfer prison inmates to the Central Mental Hospital in Dundrum for treatment. Staff there may forcefully administer medication to inmates in the same way as to a ‘non-voluntary’ service user under the Mental Health Act (2001).
Aisling

I conducted my final interview in the field with Aisling six-months after leaving the CMHT. The decision to move Angela to another community mental health team dominated Aisling’s conversation. It left Aisling very upset but she appeared conflicted; she deeply missed Angela’s presence in her life, yet wondered if the change did her good. She spoke of how it allowed her to move on with a ‘new person’ [nurse] who had no preconceived notions of her or her ‘...baggage’ (Aisling’s word).

The last I heard was that Aisling returned to college six months after my final interview. She was still living in her home in the community. She received an injection of anti-psychotic medication two weekly and attended the clinical psychologist who worked with her using cognitive interventions.
Chapter 9: Discussion

Toulmin (1992:132) argues that explanations about problems are influenced by ‘external’ context and action. Acknowledging that scientific ideas have hidden as well as explicit agendas, he considers that we need to examine how secondary interests are served in the ‘solutions’ science presents. The notion that solutions derived from rationality are timeless, abstract and universal can no longer provide an adequate platform on which to base assumptions, and Toulmin (1992) argues that the maxim of trying to handle problems rationally needs reconsideration. The ‘situatedness’ (time and context) of problems, previously discounted by Descartes, can no longer be ignored or considered as a separate non-entity. With the recognition of the ‘applied’, the real life context is not something peripheral to be discounted, but a phenomenon that must be viewed as at the core of problems. It is this ‘situatedness’, along with the inherent complexity of problems it brings that this study attempts to elucidate.

All we can do is begin from where we are, when we are there; it is not possible to consider the technical separate from the moral. Care in schizophrenia, with the conflict between the autonomy of the individual and the ‘control’ expectations of society place morals and ethics firmly at the forefront of psychiatry and nursing interaction. Any attempt to distinguish between the technical and the ethical, is overwhelmed by the practical demands of new problems and situations, so we can no longer separate ‘pure technical science’ from ‘applied practical situations’. Toulmin (1992) views technical and scientific solutions as part of an ‘unreconstructed’ modernity. He believes the pursuit of ‘rational method’ led to the devaluation in merit of other schools of thought, such as rhetoric and ethics. Our difficulty is that if we continue to work from notions of ‘unreconstructed modernity’, characterised by rigour, exactitude and systematisation, then our encounters with problems become devoid of context. The result will be that we fail to evaluate the situation in all of its complexity. Our responses become systematised, rigid and impersonal. In this, the institutions derived from modernity, such as psychiatry, risk the creation of ideas and solution that are not just ‘unstable but sclerotic’ (Toulmin 1992:184). We will be unable to adapt to the challenges that time and context bring; there are no formulas that can be applied. Sound rhetoric demands that we challenge this standpoint and ‘speak to the condition of the audience’ in all its contexts and complexities, an understanding that requires us to ‘listen to their condition with equal care’ (Toulmin 1992:176).

The analysis of care in ‘schizophrenia’ presented here, relates ‘in context’ the events from a year of ethnographic practice in a community mental health team. Rather than an ‘objectivist’ view and a rationalisation of the variables such as the analysis of the role of genetics or environment in causation, the analysis presents the lives of people diagnosed with ‘schizophrenia’ in context, in conjunction with the lives of those who care for them and those

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96 Toulmin (2002) differentiates the modern day understanding of ‘rhetoric’ from its origins as the Ancient Greek school of thought exemplified by Aristotle, which played a central role in the development of western civilisation. Rhetoric provided a heuristic in understanding complex situations, built on the five canons of invention, arrangement, style, memory, and delivery. The most common usage of rhetoric is in the political domain, used as a tool to influence decision-making. Contemporary views of rhetoric consider its extension to wider domains with the capacity to resolve conflict through using common and shared features of ‘symbols’.
who work with them. During his interviews for ‘The Foucault Effect’ (Burchell et al. 1991:76), Foucault describes this form of analysis as ‘eventalization’, a means of ‘rediscovering the connections, encounters, supports, blockages, plays of forces, strategies and so on, which at any given moment establish what subsequently counts as being self-evident, universal and necessary’.

**Ambiguity in the context of psychiatric nursing in Ireland**

Government policy on mental health in Ireland is perhaps undergoing its most significant shift in its philosophical standpoint in 200 years, moving towards a vision of recovery orientated services, delivered by community mental health teams, primarily nurses (Government of Ireland 2006c, Mental Health Commission (Irl) 2006). Ireland provides specific training in psychiatric nursing, yet as a resource, the authors of ‘Vision for Change’ (Government of Ireland 2006c) regard the psychiatric nurse as a costly, underutilized, ineffectively deployed resource, with psychiatric nurses considered as operating below their level of expertise. When it comes to clinical practice, the authors consider that psychiatric nurses are given little opportunity to deploy their expensively acquired expertise. In addition, they question whether psychiatric nurse education and training currently meets service user needs.

Cowman et al. (1997) consider that psychiatric nurses in Ireland emerged as a distinct group in 1921 with the formal education of the asylum ‘keeper’ in Ireland. The remit of this role was clearly defined, that of ‘surveillance and control’. In the latter part of the 20th century, along with general nursing, psychiatric nursing strove for elevation to the status of a profession and, in its pursuit of knowledge, began to look beyond its roots of medicalised thinking. Nolan (1993:13) believes that after 150 years psychiatric nurses are still engaged in a quest to establish a unique identity, a quest that has resulted in ‘inter-professional rivalry, jealousy, and suspicion’. Jubb-Shanley and Shanley, (2007) consider that psychiatric nurses of today are confused about their role due to considerable variation in the type of care they provide and the limitations in their knowledge base as practitioners. They believe the confusion has resulted in a loss of confidence and competence in what nurses can contribute to care.

As it struggled with its identity, psychiatric nursing received new power in the control of the ‘mad’. Nurses, like psychiatrists, judges and police under new mental health legislation, were empowered to override the fundamental human right to liberty. In addition, under the Irish Medicines Board Act (Government of Ireland 2006b), legislation allowed nurses limited prescribing rights for psychotropic medications. Yet, despite the new powers, psychiatric nursing still struggles with its role. Whilst grappling with its identity, it faces another challenge, the demands of the ‘mad’ to self-determination in their own care, with the individual having the right to claim ‘nothing about me, without me’ (South African Disability Movement slogan). This has brought with it a drive within Ireland to a more psychosocially orientated approach encompassing recovery (Mental Health Commission, 2005). This change has forced psychiatric nursing to re-assess its relationship with ‘mad’ individuals, challenging their traditional role as an agent of social control. The move to working in community mental health teams has compounded these problems, as Onyett et al. (1997) identify that team members are struggling to establish the priorities between allegiances to professions and working towards shared goals for service users. Yet, despite being the most numerous group of caregivers and the only
professional group that services users speak well of, people rarely identify nurses as influencing the recovery journeys in survivors' accounts.

Research literature rarely examines the nurse's effectiveness in care delivery. Although the ‘Vision for psychiatric/mental health nursing’ (Health Services Executive 2012) acknowledges psychiatric nurses have enhanced their skills, they still need to develop the areas of holistic recovery oriented assessment, assessment of risk, psychosocial interventions, and professional and clinical leadership. It identifies that both the 'medical model' and the 'organisational culture' inhibit the development of the nursing role in practice. At present, developing theories on nursing practice involving psychosocial approaches and problem-solving interventions, remain critically underutilised. The nurse's role in practice continues substantially under the influence of the 'medical model', largely confined to the management of safety, pharmacological interventions and acting as a brokerage for services provided by other disciplines (Shanley et al. 2003). The ‘Vision for psychiatric/mental health nursing’ (Health Services Executive 2012) document highlights investiture of executive clinical decision-making power in consultant psychiatrists as responsible for determining the treatment choices available within the CMHTs. For many people with a diagnosis of schizophrenia, this means the use of psychotropic medication is the only option available.

The core of the ethnography
This ethnography presents evidence of how psychiatry as a field of medicine struggles to cope effectively with the diagnosis of schizophrenia in the real world. It illustrates the stigmatising nature of the diagnosis and the difficulties the diagnostic term creates. In these circumstances its language can create more problems than it solves. The problems it encounters frequently are not the problem of schizophrenia but are the problems of interactions. As in the case of Andrezej, social circumstances, such as coping with family needs, dictate the nature of the relationship people with a diagnosis of schizophrenia have with those who attempt to help them cope. As we see from the number of people with a diagnosis of schizophrenia allocated to the clinical nurse specialist, in an equitable service each person might receive a twenty minute interaction every three weeks. This creates a service where conforming to medication and risk aversion still predominate in the focus of interactions. The absence of knowledge and reluctance to use more time consuming interventions as viable treatment alternatives, leaves a significant void in the choices of which people can avail.

This study has proved to be a very personal journey. Before I started it, I knew that 'schizophrenia' troubled me, however I had not realised the extent to which these troubles influenced my behaviour. I could not have framed these troubles in the context of 'dissonance', nor realise the complexity of their nature. Neither had I realised the behaviour it generated in me and the extent to which I would need to question the 'honourableness' of my actions.

Central to this ethnography is the notion of 'professional dissonance' that the diagnosis and treatment of 'schizophrenia' creates and the manner and ways in which psychiatric nurses, including myself, attempt to reduce the dissonance experience. Although there may be an impression that there is growing convergence between the biological, psychological and social perspectives on the causation of schizophrenia (The Schizophrenia Commission 2012), the reality is that ideological disputes regarding the biological/psychosocial dichotomy and the
residual legacies of dichotomised thinking still pervade in practice. The advocates of a ‘post’ psychiatry, steadfastly argue for a reconstruction of how psychiatry negotiates its relationships with those it ‘treats’, however their mainstream counterparts believe their actions are remiss in supporting recovery principles and wish to reclaim the ‘patient’ for psychiatry. In the disputes over the relevance of particular perspectives, ‘orthodox’ psychiatry holds steadfastly to notions of causation, such as the role of dopamine and in doing so forget the person behind the science. It is still the reality that research evidence on the day-to-day life of the person diagnosed with schizophrenia remains neglected. With the focus of researchers firmly fixed on the technical and theoretical, the real life plight of those struggling to survive is rarely heard; a subdued and distant voice. With so few of the ‘caring community’ calling to attention the plight of these voices, society has all but abandoned them; what I cannot hear, I do not see.

Throughout the fieldwork, it was seen that as practitioners struggled with various interpretations of schizophrenia, they continued ‘historic’ ways of working that perpetuated the fashioning of people into ‘docile bodies’ (Foucault 1991), who conform to the needs of service delivery. Here, psychiatric nurses are key re-enforcers of ‘schizophrenia’ narratives that are underpinned by biological understandings and pharmacological intervention. These narratives, thus contribute to the ‘biography of the self’ that people diagnosed with ‘schizophrenia’ come to construct around their life; such as those documented by McCann and Clarke (2004) which suggest that people view themselves in the context of illness. The stories of the young lives demonstrated here exemplify how schizophrenia and its care becomes a part of the relationships they form. The treatment they receive in the form of anti-psychotic medication also alters their physical form; weight gain changes their body image, while also stifling their creativity and thought. In combination, these effects change who they perceive themselves to be and of what they are capable; their identity changed. This reconstructed identity becomes a source of shame, embarrassment and self-stigma, and as in the case of Sarah, limiting her engagement with society. At present, the reality of the schizophrenia diagnosis is that ‘everybody’ believes they are ‘right’, yet nobody is ‘right’, and in clinical practice, when confronted by the clashes of values, beliefs and priorities caused by the schizophrenia diagnosis, ‘professional dissonance’ is a ‘reasoned’ response.

There are many sources from whence my dissonance came. I want to conceptualise this visually (Fig. 15), in order to display the extent and complexity of their origins. When working with the diagnosis of ‘schizophrenia’ as a part of a community mental health team, ‘professional dissonance’ is fraught with complexities and using dissonance reduction strategies frequently generates spiralling levels of dissonance. Presented are four domains, the dissonances of ‘language’, ‘costs’, ‘correct training and docile bodies’, and ‘vicarious dissonance’, where the ambiguities of schizophrenia manifest as dissonance for psychiatric nurses in practice.

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97 Thesaurus: English (U.K.): ‘Reasoned response’: Coherent, rational, logical, lucid, analytic, cogent, thought through, sound or well-structured reply
In an attempt to reduce the dissonance experienced, psychiatric nurses, including myself, resort to various strategies in an attempt to reduce dissonance. These are presented visually in Figure 16 below. Principal amongst these is how nurses formulate their own interpretations of the individual’s ‘schizophrenia’ experience, based on ‘their’ understandings of ‘evidence’. For many nurses, perceived powerlessness in the ability to create an effective change or the necessity to remain in employment, are sufficient to allow them to reduce or ‘tolerate’ dissonance. Often this is enough to maintain the status quo. Dissonance theory also predicts that people can change their mind about the contested fact and accept the ‘new cognition’. If this does not alleviate the dissonance, they can choose to seek out ‘new’ evidence, however usually they do this in such a way that they hone in on evidence that strengthens their case. They selectively identify more evidence that supports their standpoint, at the same time disregarding or denigrating the evidence that detracts from their view. Using this strategy, to their eyes, the evidence ‘in favour’ becomes overwhelming or irrefutable and their position hardens, with greater entrenchment of their views resulting. I have noted this in my own behaviour over the past seven years, building ever-stronger cases for my views, whilst trying to find information that detracts from the strengths of the opposing arguments. The net outcome of these dissonance reduction strategies when encountering dissonance in schizophrenia, is that you come ‘...to believe what you want to believe’.
The issues
Unlike other forms of research it is difficult in ethnography/autoethnography to make prescriptive recommendations, in fact this could be construed as being counter the methodology. It is very much in the reader’s interpretation of the ‘graphy’, the writing, where likely interpretations of the requirements which might be necessary are made.

The nature of the relationship of ‘big pharma’ and psychiatry continues to present challenges to clinical practice. Today pharmaceutical companies and psychiatry reap the rewards of this relationship. Americans now firmly believe that serotonin is the root of depression and that ‘schizophrenia’ is caused by a chemical imbalance of dopamine (Whitaker 2010). Yet there is no empirical evidence for either of these hypotheses. Such has been the success of marketing both of these categories of medication that these theories, now firmly embedded within the minds of the general population, convey an understanding that these illnesses ‘are’ biological entities, and that the only way to counteract the problems, which people encounter, is with medication. This is where Whitaker (2010) firmly roots the emergence of an ‘epidemic’ of mental illness.

In my dealings with all of the members of the team including the psychiatrists, I found each assiduously scrupulous and ethical in their conduct when dealing with representatives of the pharmaceutical companies. I did not note any variation in their prescribing practices following visits. Yet the subliminal presence of the companies still pervaded. Nurses were central to distributing the material pharmaceutical companies brought and reinforcing families need to monitor compliance with medication. These are key in maintaining families’ perception that only medication is beneficial. The presence of information distributed by pharmaceutical companies in raising ‘disease awareness’, still represents a significant challenge. Perehudoff and Alves (2011) identify their intent in advertising is primarily the pursuit of maximising corporate profit, with thoughts for the individual a far lesser concern. Sponsorship by the pharmaceutical industry of service user and family support groups in particular, present great difficulties for those organisations in the ‘impartial’ representing of views. Perehudoff and Alves (2011) conclude that the financial relationships between commercial entities and support groups

Figure 16 Reducing Dissonance
threaten to stifle the independent ‘voice’ of these groups in the process of formulating policy and perpetuate biological narratives in the consciousness of the public.

The world of mental health now talks of recovery and authenticity in its engagement but this study shows that in the context of ‘human-to-human’ engagement, human nature still has its flaws. Even though nursing’s targeted education may allow nurses to demonstrate consistency in their external personae of espoused values and beliefs (Rogers & Kashima 1998), the frustrations of working with the diagnosis of schizophrenia, such as my own experiences with Sarah when I resorted to ‘punishment’, expose the frailties of the human condition. This reveals the self-serving nature of engagement and the crossing of boundaries to which nurses can resort at times.

Managing boundary issues is a key aspect in working with the diagnosis of schizophrenia, as breaches do contribute to the erosion of the therapeutic relationship. The study illustrates my hypocrisy in the application of double standards when establishing boundaries; it was all right for me to impose boundaries and, when I felt like it, to breach them, but for the people with a diagnosis of schizophrenia that I worked with, it was not. Determining the most appropriate response to boundary crossing is very difficult. Martinez’s (2000) model of boundary crossing offers a good framework for staff on which to gauge their response to people. The evaluation of the five domains98, when answered truthfully, especially the professional’s motives and intentions, provides a good measure as to the most appropriate response.

Over the course of the fieldwork, I saw the greatest challenge that the team faced as its lack of service user perspectives in the planning and delivery of both services and care. It is heartening that through its involvement in this research, the team progressed to build its links with its affiliated education institution, the Irish Advocacy Network and Shine. With the involvement of service users and carers, together the group secured a national research grant to develop in the delivery of a peer and clinician led psycho-education programme for people with severe mental health difficulties.

The ‘recursive’ nature of social activity continually recreated by social actors (Giddens (1984:2) does not just apply to nurses relationships with service users: it also exists in the dynamics of the CMHT. As seen in the ‘hierarchy of the blue chairs’ in chapter 4, knowledge of pecking orders and one’s status clearly exists. Although I did not note major conflict amongst the team members, in the recursive nature of relationships, nurses’ place within the hierarchy was perpetuated through subtle and nuanced acts of conformity and the learned ‘silence’ they maintain about decisions. It is a key outcome of socialisation. Nevertheless, this type of relationship does serve a dual need. As I struggled to cope with the frustrations of my relationship with Andrezej, in the end I was happy for the consultant to make the decision of ‘banishment’ for me as I felt I had done as much as I could. I ultimately felt uncomfortable with the responsibility and was happy to hand over the decision to somebody above my ‘pay grade’.

98 Martinez’s (2000) five domains were i) assessing the potential for benefit or harm to the person, ii) the presence or absence of coercive and exploitative elements in the boundary crossing, iii) the professional’s aspiration to professional ideals, iv) the context of the boundary crossing and v) the professional’s motives and intentions
How nurses and others are prepared for engagement

McKenna (2003) considers that a peculiar state exists in psychiatric nursing, where there are considerable variations in knowledge and understanding surrounding practices in mental health. At the end of this fieldwork, I find myself trying to place the dissonance I experienced in context. I question whether my experience of dissonance is greater than those of others. If my socioeconomic status and educational attainment are taken into account, as in the work of Snibbe & Markus (2005), then perhaps my dissonance is greater than others. My move to college places me in a situation where the 'culture' underpinning my nursing has changed. In college I interpret my 'nursing' role as one determined by an 'agentic' framework, rather one than one more normally fashioned by 'holistic' cultural tendencies of nursing in practice, the prevailing ethos within the university being more reflective of 'agency'. This perhaps exacerbates the magnitude of dissonance I experience. The movement of nursing to more advanced roles, challenging nurses to critically reflect on knowledge increases the potential for dissonance and the increase in autonomy associated with the advent of specialist roles shifts the cultural footings to more 'agentic' parameters. The increased autonomy in practice for nurses potentially increases the capacity for dissonance and the need to be able to tolerate dissonance and 'uncertainty' as a feature of practice. Nevertheless, my dissonance is not entirely reflective of the level of education that I have attained, rather it is the content of the education and the way my educators presented their challenges that fuelled my dissonance. The questions posed by my educators, like where the relevance of trauma and abuse fit into the frameworks of genetics and biology in schizophrenia, challenged what I took for granted.

"There is no neutral or natural place in teaching"

(Derrida 2002:69)

The influence of educators and the content they present raises particular challenges for educators in the content of the programmes they teach. As educators, we must understand the nature of the content we teach and its propensity to create dissonance. We need to acknowledge the radicalising capacity of the classroom. It behoves us to remember that what we teach has a direct relationship to the outcomes of people’s lives. The struggle of late modernity is to be ethical, whilst at the same time being aware of dissonance. The ethic of the classroom is not in knowing the theory but also elucidating the contra position of both perspectives and in the use of rhetoric to challenge the validity of both sides of arguments. At this point, nothing is hidden, and the irony of the inconsistencies laid bare. Otherwise, the more we include content contra the orthodox psychiatric perspective, the more our students will struggle with dissonance in practice, without the capacity to tolerate ambiguity. Therefore, we need to consider how we can help them to learn how to tolerate ambiguity and cope with dissonance if they are to survive. If we fail to do this we risk the perils of increasing conflict in practice; people with a diagnosis will suffer as a consequence and attrition rates in the profession will rise.

Role of the individual psychiatric nurse in the determination of ‘schizophrenia outcomes’

Like Wells (1997), I have concluded that community mental health teams function as ‘street-level bureaucracies’. As a sensitising concept in this study, ‘street-level bureaucracy’ has
relevance not just in the context of organisation and policy, but also in the face-to-face interaction of nursing engagement. Psychiatric nurses working in CNS roles have high levels of autonomy in this face-to-face interaction and here the principles of Lipsky's (2010) thesis have particular relevance. Whilst managing high pressure caseloads and balancing the goals of the organisation with the demands of acting autonomously as professionals, the contrasting perspectives on the diagnosis of schizophrenia create dilemmas for nurses in practice.

In working with people with the diagnosis of 'schizophrenia', the psychiatric nurse's role is contingent on the vision that people have about themselves and the condition. Depending on the time, the individual accesses the service, the arbitrary allocation of key nurses means the individual he/she enters into a relationship with, results in very different explanations of 'schizophrenia'. The interventions they receive and information on the effectiveness of treatments ultimately influence the course of the individual's life. Although not alone in having influence, nurses as the people with greatest durations of contact with people given the diagnosis, are instrumental in constructing the version of 'schizophrenia' with which the person diagnosed comes to identify. For the people engaged with the service, nurses act as gatekeepers to the psychiatrist, determining when and if the person diagnosed with 'schizophrenia' requires intervention. When they do this, they prime interactions with their interpretations of events, in an attempt to 'steer' care in the direction they perceive as 'best'. Svensson's (1996) argument is that with countless alternative treatments and rehabilitation options, in order to cope with enduring health problems in a complex system of health and care, it is essential to consider the person's preferences. Not only must we take into account his/her values and individual potential, we must also include his or her experiences and social situation in decisions (as in the example of Andrezej's medication - chapter 8).

Despite the team perceiving that it used very little 'control', the study showed people had little choice in care, and when not agreeing with the team's perception of the most appropriate care, they were subjected to control in the form of 'coercive proposals'. Even at the end of this study, I cannot answer the question as to whether it is justifiable to use coercion. My answer is both yes and no. Even Nozick's (1969) treatise on coercion does not provide definitive guidance. We can only as individuals, be guided by our conscience as to our true reasons for its use.

The study found that nurses still heavily rely on practices imbued with pharmacological intervention as the mainstay of their engagements with people. For many, the use of psychotropic medication is the only option available and nursing practice remains substantially under the influence of biomedical psychiatry, with the psychiatric nurse's role confined to the management of safety, pharmacological interventions and acting as a brokerage for services provided by other disciplines (Shanley et al., 2003). At present theories involving psychosocial approaches and problem-solving interventions, remain critically underutilised by the nurses. Yet despite their reliance on pharmacology, as previously identified by Higgins et al. (2006), the information they provide on the adverse problems of medication is sketchy. This she attributes to the fear of jeopardising relationships, inculcating non-compliance, destabilising existing balances, causing disharmony or fearing retribution within the team.

A barrier to people developing an understanding of their 'schizophrenia' diagnosis is the canonization of risk by nurses within the team. Motivated by self-protection and defensive
practice to reduce their own and the service's exposure to blame, they have not learned to tolerate 'risk' during their interactions with people experiencing strange thoughts. This inability to tolerate 'risk' leads to increased use of anti-psychotic intervention, coercion and the breakdown of therapeutic relationships. Gunstone (2003) identifies that tolerating risk is a 'grey area' due to its fluid nature. As seen in the case of Greg, the levels and types of risk nurses tolerate are variable, dictated by the team member present on the day. The capacity to tolerate risk is an individual capacity, which shifts with time, and increases with the exposure to problems as people become desensitised. Onyett (1997) notes the effect of the individual team member's power within the group on the perception of risk and identifies how pressure can be brought on individual MDT members who question team decisions. Challenges to these decisions can generate hostility towards individuals whilst stifling debate on topics, reducing innovation and detracting from the team's capacity to develop.

Psychiatric nurses including myself (and other mental health professionals), are not 'untainted' by the vicissitudes of 'street-level bureaucratic' behaviour. When dissonance arises, individual nurses determine what they feel is the 'most appropriate' treatment, care and outcome, based upon their 'individualised interpretations' of the diagnosis. When trying to cope, as Lipsky's analysis points out, these efforts can result in favouritism, stereotyping and the routinizing of practices that, place the needs of the bureaucrat or those of the agency first. Here they resort to the use of 'power' and 'discretion' afforded by the 'autonomy' they perceive within the role. This arises from their need to cope with dilemmas posed by ambiguity, finite resources and high workloads. When they experience dissonance, not wishing to engage in argument within the team and fearing conflict in an unequal power relationship, the exercise of autonomy becomes a covert action, done in the secrecy of private 'face-to-face' interaction, where the content of interaction is largely unexplored and unverifiable. Every extension in the level of engagement with a community mental health team provides, increases the influence and control that the team has over an individual's life. In practice the use of 'individualised interpretations' can leave the people diagnosed, and their families, conflicted and confused. Consequently, team members, who have conflicting impressions of what the priorities are, and what will work best in relation to a person's care, ensnare service users in their nets. Their actions within the team also create attitudinal barriers to offering integrated interventions, leading to under-appreciation of multidisciplinary inputs. When conflicts and clashes of beliefs occur between differing interpretations on the diagnosis, the 'events' that arise are formalised as risk, with 'solutions' imposed through using pharmacological intervention.

The pressures of the workplace and the ambiguities of the schizophrenia diagnosis, at times, cause nurses to place their own interests and objectives over those of the people they care for and work with. To cope with this they resort to controlling agendas and the flow of information. I personally attempted to reconcile the dissonance I experienced that way. At the same time, I also saw other team members experience their own forms of dissonance and try to cope with them in their own ways that were different to mine as in Claire's arguments on the cost of care.

**Reflections on the use auto-ethnography**

Conducting an autoethnography has not been an easy process, even for someone who, as Ellis (2004) alludes to, has had the benefit of psychotherapy processes. The fact that the final writing up of this thesis has taken three years since leaving the field may be testament to Ellis' (2004)
view that men can find it harder than women to talk about their emotions and difficulties. Be advised, it is a process that takes time. The spending a full year in the field can be a luxury that few can afford, but it is this level of contact with the field that provided for the longitudinal nature of the data that proved essential in the emergence of the core construct.

The challenge of undertaking the care of people, such as those with a diagnosis of schizophrenia, and sustaining an extensive research project is not an exercise without challenges. Chief in this regard is that of going ‘native’. As in the analogy that where you think ‘...you may have crossed a line’, only to look back and realised you had done so ‘...a long way back’, so too with the phenomenon of going ‘native’. If you reach the point where you think you may have, the realisation, in all likelihood is that it happened much earlier. As Delamont (2005) identifies, you will rarely have a person tell you at the event. The probing nature of autoethnography is one that involves intense emotion. Where the undertaking is to place the priority of care over the conduct of the research, there will be interference in the capacity for ongoing data analysis, and if the experience of this study is anything to consider, allow for more time.

As Hammersley & Atkinson (2007) identify dilemmas can exists on outcome of the research in the emergence of the core construct. I believed I set out with a clear objective in what I was trying to do, which was to look at how I could learn to practice in a better way through working with a team, who I still believe are the best team with whom I have ever worked. In the solitude of the analysis, I became increasingly aware of how the outcome of this work radically altered from my initial intentions, however this should not be regarded as an unusual event or indeed to be feared. Here the constant encouragement of my supervisors that in the richness of my data there were answers, allowed me to struggle through.

I am very conscious of how my initial ‘overt’ intentions might now be interpreted by both the team and service user participants as ‘covert’. In my methodology chapter (chapter 3), I identified two capacities of ethnographic research where I felt its suitability would meet the study’s original objectives:

i) The need to understand the interpersonal/therapeutic relationship and how nurses working with people with a diagnosis of schizophrenia develop meaning through a social interaction

ii) To explore the process of engaging with a person diagnosed with schizophrenia

Yet, despite my questioning of how the outcome of this study has departed from the original intention, there are answers to both of these objectives, it is just the answers are not those I intended in the questions I originally posed. They certainly were not the ones I expected to find. As stated above, my hope was to identify the elements of best practice from the team recommended as the best available, not to embark on a journey of finding fault and questioning the fundamental basis of my practice, as I feel I have done.

I am conscious of the political nature of ethnography (Van Maanen 1988, Crang & Cook 2007) and the problems it poses in constructing the final piece. Since my reading of Ellis (2004) and my engagement with this work, I am deeply aware of how impossible it is to capture the ‘truth’ of an experience, here I can only present what happened from my own perspective of the
situation, acknowledging that it is a selective story. I know that other people’s interpretation of
events will fundamentally differ from mine, but every story can only ever be a partial and
situated portrayal of what has happened. As an autoethnography, as Denzin (1989a:34)
acknowledges, what has emerged is not the account of an ‘objective outsider’. Nevertheless,
this is how my dissonance arose; these interpretations of events were responsible for the ways
I acted. Sometimes, they were deeply misguided. It is the concept of dissonance and coping
with dissonance that are the core, not the individual interpretations of schizophrenia or the
consistency of people’s beliefs about the diagnosis, which are at issue. Equally, if I believed in
biological interpretations and lived in a psychosocially oriented world, dissonance would still
result. I feel this autoethnographic method is the only way I can help people understand the
nature of reflections that contributed to my actions in care.

The difficulty in writing this account is that it fundamentally challenges Holman Jones’ (2005)
criterion of ‘participation as reciprocity’ in judging the quality of the ethnography. The work
attempts to reconstruct my participation with those in the field. However, at the outset, I little
understood how this outcome would differ so vastly from the representation of my objective. I
do not know now whether I have met the criteria of ‘mutual responsibility’ and ‘obligation’, as
people may believe they agreed to something else. The only defence I can offer is that following
my encounter with noted ethnographer Professor Martin Hammersley before entering the field,
in my explanations of ethnography to people I would state that ‘an ethnography goes where an
ethnography goes’. It became a mantra of sorts; the data determines the outcome. I tried to
avoid preconceived notions. I suspect many of those to whom I said this, now reading the
account did not see the significance of what I meant.

Where do I now stand?
I have been challenged to adopt a strong position in relation to myself in the study. In this
ethnography, for me there are matters which are still unresolved, my dissonance still exists and
aspects of the accounts are still raw and, as may be self-evident to a reader, still charged with
emotion.

The formulation of my original question rested in my inability to reconcile the ambiguities in
theory and practice, my study appears to have intensified rather than resolved these issues.
Although Spry (2001) points to autoethnography’s capacity to transform by creating efficacy
and healing in communal lives, in the short term rather than resolve ambiguities, it appears the
cracks are now more visible, at least more visible to me. Perhaps this marks the first stage in
this process, a necessary stage in making visible the hidden and illuminating it in context. In this
way, spaces for resolution may become evident.

Perhaps I rest in the area of the symbolic interactionist perspective on schizophrenia (Rosenberg
1984). I feel it offers hope for understanding people’s experiences in a less stigmatising way
than that of medicalised theory. While the symbolic interactionist framework provides for the
use of medication, it also embraces other avenues of approach. In viewing the condition as a
failure in role taking (Doubt 1996), our response can be to provide interventions where we try
to understand, where we try to make the person understand or try to make the person
understandable to others. The interventions of medicine and those within the psychosocial
framework, become understandable, as effective interventions when working with the
individual in trying to cope with the patterns of behaviour that 'others' cannot understand, replacing them with ones that they can. Then it becomes a journey of recovery; one of ‘hopes and dreams’.

**Limitations**

The greatest limitation of this study is that it can only ever, at best, be one person’s interpretation of the events. The volume of data to emerge from the field was vast and the analysis lengthy. The construction of the layers within analysis and the emergence of the central construct meant that by the time analysis reached its ‘final’ incarnation, as represented in this account, I found that I did not have the capacity to further validate the interpretation or acquire additional data.

In Chapter 3, I offered an alternative framework for the evaluation of autoethnographic research in the context of Holman Jones (2005:773) quality criteria for autoethnography. I will now attempt to revisit those criteria in the defence of the limitations of the study. The six criteria are now explored individually in the form of a self-evaluation of the work.

1. **Participation as reciprocity:** how well does the work construct the participation between the author, performers and reader, marked by mutual responsibility and obligation? Here, I have tried to remain true to the data, what is presented is an account of the interactions between the various actors in the study. Where possible in the reconstruction of the events, I have endeavoured to recount not just the event but the internalised processing of thoughts, beliefs and actions on my part. Where possible I also included as many perspectives on the event as I could form, both multidisciplinary team members’ perspective and those of the service user him/herself. At all times in the study, the needs of service users took precedent, my clinical responsibility taking priority in my obligations before my research.

2. **Partiality, reflexivity and citationality:** how well does the work present a partial and self-referential tale that connects with other stories, ideas, discourses and contexts as a means of creating a dialogue among authors, readers and subjects? As presented the study has followed the course of people’s lives in my attempts to illustrate events and connect these to the discourses. Each ‘event’ is placed in context, with a discussion in depth of the theory and literature relevant to the experience. Conventional explanations are not accepted at face value, and as an individual I have exposed my personal frailties and inadequacies to provide as detailed and in-depth view of the events.

3. **Dialogue as a space of debate and negotiation:** how well does the work create a space for and engage in meaningful dialogue among different bodies, hearts and minds? The thesis opens a dialogue on the topics concerned, reflecting the struggles for both me and the people with whom I worked. It displays the emotions that working with schizophrenia engenders, providing both context and depth for the analysis of the events. The work, I feel, offers the reader sufficient information to retrace the events, and should provide sufficient detail to allow readers to think back to comparable situations from their own lived experience and apply the outcome of the analysis.
4. **Personal narrative storytelling has an obligation to critique:** how does the narrative and story enact an ethical obligation to comment on subject positions, acts and received notions of expertise and justice within and outside of the work? Adding to the ‘vraisemblance’, I proffer that what I present is a frank and honest exchange with myself; on my thoughts, motivations and actions in practice, with few facets left that I have not probed. In what might be considered in some parts a ‘confessional tale’ (Van Maanen 1988), I have laid bare innermost ‘secrets’, ones which I believe in all likelihood I would not have shared or admitted to an interviewer. Part of my evaluation in the emergence of this discussion has been to consult others in their experiences that are parallel to mine. Thus far, the responses that I received, found resonance with my audience and acknowledgement that they too were ‘...that soldier’, whilst those from other disciplines I have spoken to accord the same feelings in the areas of their own ‘taboos’. In light of these perspectives, I would consider the critiques of events as presented are valid.

5. **Evocation and emotion as incitement to action:** how well does the work create a plausible and visceral ‘lifeworld’ and charged emotional atmosphere as an incitement to act within and outside the context of the work? As indicated earlier I have asked others for opinions on this piece. All have described their emotion as they have encountered the accounts of the episodes. As a piece, for good or bad, I feel this work does evoke emotion. It is in the generation of this charged response, where people are confronted with hopelessness, futility and challenges, they are asked to reflect at the ways they have acted in the past, in the context of perspectives that they have not considered previously that become an incitement for action.

6. **Engaged embodiment as a condition for change:** how does the work place/embody/interrogate/intervene in experience in ways that make political action and change possible in and outside of the work? The analysis and discussion presented on each event demonstrate where the need for change exists. The work identifies an area not previously considered, how the ‘schizophrenia’ diagnosis creates dissonance for clinicians in practice, how they attempt to cope with it and what the consequences of what those actions are. This creates a platform for understanding our ways of working and what practice needs to consider for functioning in the multidisciplinary environment.

**Coping with dissonance in the wider context of healthcare**

You may think that this thesis is just about ‘schizophrenia’, but it is not. In place of ‘schizophrenia’, we may substitute any healthcare practice where there are contentious and varying values and beliefs at the heart of care. The lessons here are extended to the likes of value clashes between natural and managed delivery in midwifery; the debates between person-centred care and medicalised identities in intellectual disabilities; in general nursing the debates on resuscitation (De Vries 2008); in children’s nursing the dilemmas resulting from the dilemmas posed by child protection.

The construction of individualised interpretations creates problems. Where dissonance occurs, a characteristic response is to seek out information. The difficulty in this being 'you seek out the information you want', selectively supporting your standpoint, reinforcing beliefs and leading to positions that become more entrenched. Yet, in the construction of the model, people
become little different to those who they find themselves in conflict with, who subscribe their own particular version of the condition, the psychiatrist, the psychologist, the sociologist, the survivor and to what ends? In formulating an approach such as this, the nurse can operate as a ‘rogue’ practitioner, working ‘off radar’ and operating ‘covertly’. In this mode, nurses use ‘discretion’ in their interpretations and thus exercise ‘power’.

These individualised theories influence service providers, service users, and families’ views on cause, treatment and recovery. Yet, in these individualised interpretations, large potential exists for new dissonance to arise, not least of which is the onset of dissonance awareness and consciousness of ones actions, and the initiations of relationships, which after ones departure, likely cannot be sustained. When individuals cannot cope with dissonance, they walk away.

As a microcosm of an interdependent society, vicarious dissonance is present in the multidisciplinary team; it is especially present when highly interpersonal factors are provoked. As posed in Hill’s unpublished thesis (2005), cited by Cooper (2007:151-152), I might similarly ask: do nurses reside in a state of "double-consciousness" like ‘Black Americans’? Here, Hill argues that the perceived impact of influence a person believes he or she can have, acts as a moderator for the level of dissonance he or she experiences, ‘the less influence I think I can have, the less dissonance I experience’. This may be one factor in nursing’s tolerance of dissonance.

We need to provide a range of ways of working and an understanding of these theories whilst at the same time being able to do this in a way that can tolerate differing perspectives without bringing these into conflict. It is easier for the psychiatrist to practice within the sphere of her or his own discipline, untethered by the conflict of a relationship that is subservient to other disciplines’ knowledge bases. Nursing is not in that state. Its adherence to one perspective or another can bring it into conflict with other members of the multidisciplinary team. As a psychiatrist, one can choose to believe/practice using whichever approach he chooses, and one has the power to follow that path. A psychologist can make a similar choice. As a nurse, I am limited in my capacity to make decisions working as I do to the agreed treatment plan of the team but under the direction of the treatment choice, approved by the psychiatrist.

**Implications for further research**

This study reveals that within the multidisciplinary team there is little concern for the content of interaction or the effectiveness of key workers’ face-to-face interactions when working with people given a diagnosis of schizophrenia. Unless the key worker indicates a problem, the team displays no interest in exploring the nature of interactions and, even when concern is expressed, the team considers little outside pharmacology as a solution. This reveals a marked lack of desire to use the interdisciplinary peer review mechanisms supposedly central to multidisciplinary functioning. It also reveals that for those with long-term relationships with the service, there is little desire to progress recovery perspectives when people are maintained on anti-psychotic medication. There is a need to explore the functioning of community mental health team working practices in developing mechanisms where it can help individual practitioners enhance their interactions to improve the quality of life for people given a diagnosis of ‘schizophrenia’ in a way that supports recovery, rather than contributing to a biography of self, blighted by shame, embarrassment and stigma. As nurse educators we cannot
allow our students to become mired in the debates over theories of little causal effect; we need to concentrate on the aspects which will allow them to work with people, helping them to cope with the experiences of ‘schizophrenia’ in the contexts of their lives.

The moral of the tale

In the conclusion of the study, two aspects emerge very strongly. The first is the capacity to engage with people in situations and spaces commensurate with their needs, encompassed within the values of tolerance, forbearance and patience. Secondly, teams need a capacity to create discourse spaces in time, which can accommodate the values, beliefs and perspectives of all members of the multidisciplinary team and service users. This will require scope for each person’s individual perspective or model to be included; scope for discussions on care in working relationships that can tolerate ambiguities, and provide broad-based intervention.

In the events presented, the outcomes of care can be placed in perspective. In the case of Andrezej, the intervention of the criminal justice system may or may not have been avoidable; Andrezej’s encounter is likely not attributable to the diagnosis of schizophrenia. Whether his ‘banishment’ by the community mental health team accelerated this process, may be a moot point. His confinement would ultimately frame his perspective of ‘schizophrenia’ in the short term.

For Greg, the imposition of a pharmacological solution and the nature of the proposal altered the course of his engagement with the service and his ability to develop further his understandings of his experiences. The team by their actions diminished his capacity to trust those involved. His engagement appears to have become one of ‘ambivalence’, tolerating the team’s presence whilst attempting to get on with his life. The action of the team members in transposing his pattern of engagement appears to have come from a lack of understanding of his progression from the way he was working. This lack of understanding stemmed from two primary problems: the capacity of the team members to tolerate the perception and formulation as risk of Greg’s experiences, and the failure of those working with Greg to explain adequately the necessity for the way of working they were engaged within. The failure to communicate satisfactorily came from a perception of the way of working and the lack of support they might expect for the approach. The perceived absence of a discursive space where this could be done was a major factor in the event. The courage to be able to challenge perspectives safely was a contributing factor.

Aisling’s experience emerges from this study as a good example of how open discussion in spaces in time can create positive outcomes. Despite the perception of coercion, dependence and conflict within the team as to the best solution to Aisling’s problems, after the fieldwork finished Aisling appears to have flourished. Her return to college, her maintenance within the community, the retention of her ‘home’ and her continued survival are a testament to her fortitude and the work of those within the team. No single perspective on schizophrenia can claim credit for this. Aisling emerges from the combined efforts of biological, psychological and social intervention. It is in the clash and harmonisation of these approaches that Aisling’s coping derives. Within the team, the discussions of Aisling’s care were the frankest and most open. In this, the actions of her key nurse, Angela, were such that they created key spaces in time, for the consideration of actions in the context of Aisling’s ‘hopes and dreams’. As a person with
whom the team felt they could go no further, without Angela's singular action, Aisling might have experienced 'banishment' with unknown consequences. Yet in this, even the service's decision to effectively 'silence' Angela's critical voice contributes to Aisling's ability to continue to pursue her 'hopes and dreams', as she acknowledges the benefit of a relationship without 'baggage'.

Unless we can crawl out from underneath the weight of 'evidence' to encompass more broadly based understandings, unless we can see the value of the contributions of all the parties concerned, unless we can learn to tolerate the ambiguities of the diagnosis, we will remain mired in the current position. When placed in the context of working with those with the medical diagnosis of schizophrenia Toulmin's (1992:30) advice might read:

...tolerating plurality and ambiguity is the price we inevitably pay for being human beings and not gods. The omnicompetence of an autonomous group works to the benefit of those in power and contra those who are its subjects. The hegemonic representatives of psychiatry require the restraints of outside agency to hamper absolutism and arbitrary force. This requires the greater inclusion of subdisciplinary, transdisciplinary and multidisciplinary reasoning and a return to a practical modesty as encapsulated in the ideals of the 16th century humanists. Consideration of the practical, local and context bound nature of problems allows people to live free of anxiety despite uncertainty, ambiguity and pluralism.

This thinking demands reasonable and tolerant conduct, encompassing of domains of social, cultural and intellectual diversity. It requires 'modesty about one's capacity and self-awareness of self-presentation' (Toulmin 1992:195).
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Appendix
Appendix 1: Letter to Members of the Community Mental Health Team requesting support

The psychiatric nurses’ role working with people with the medical diagnosis of schizophrenia

School of Nursing and Midwifery
Trinity College Dublin
24 D’Olier Street
Dublin 2

Date xxxxxxxx

Dear Colleague,
I am a Registered Psychiatric Nurse and a Doctoral student at the School of Nursing & Midwifery in Trinity College Dublin and I am conducting a study to develop greater understanding of what the psychiatric nurse’s role working with people with a medical diagnosis of schizophrenia should be.

I am asking you to participate in this study. The results study will hopefully improve the quality of care for people with a diagnosis of schizophrenia and clarify for nurses the roles that they can undertake. Participation in the study is entirely voluntary.

Please find attached a detailed information sheet about the study and what it will involve if you are willing to participate. If you wish to know more please fill in the form and return it in the stamped addressed envelope provided. I will then arrange a time that suits you to discuss your possible involvement in more detail. If you have any questions, please do not hesitate to contact me at 01-XXXXXXXX.

All your responses will be treated in strict confidence. I hope that you will support and be involved in this important study.

Yours sincerely,

Mark Monahan
Appendix 2: Information Sheet for Members of the Community Mental Health Team

Title of the study
The psychiatric nurses’ role working with people with the medical diagnosis of schizophrenia.

Information Sheet  
Researcher Mark Monahan

From an economic, social and political perspective, getting the best from health resources is essential. The mental healthcare environment is changing radically, and as a result there is confusion amongst mental healthcare staff about their roles and the knowledge, skills and attitude needed for practice (SCMH 1997). Nursing care in the diagnosis of schizophrenia is especially illustrative of this, in the contexts of shifting perspectives on aetiology, diagnosis and treatment of the condition, post-modern critique of psychiatry, the growth of the service user movement and a shift to recovery orientated care. The effectiveness of nurses in care delivery is rarely examined, and whilst policy documents acknowledge a need for change, there does not appear to be agreement on what roles nurses should fulfil. In light of these factors, the purpose of this study is to create an understanding of the role of the psychiatric nurse working with the medical diagnoses of schizophrenia in contemporary Irish mental health practice. The study aims to identify the beliefs, values, knowledge and skills that psychiatric nurses need to increase the effectiveness of practice. It is hoped that the study will assist in future training needs and deployment of staff, and underpin educational programmes and curricula.

I propose to use an approach to research called ethnography to develop an understanding of the role. I intend to approach the problem in two different ways. Initially, using ‘elite interviewing’, it will aim to identify a contemporary view of the role of the psychiatric nurse working with the medical diagnosis of schizophrenia as seen through the eyes of figures influential in forming mental health and psychiatric nursing policy.

The second way will involve me working with a community mental health team, observing and participating in the delivery of care to service users with a medical diagnosis of schizophrenia. I also propose to interview members of the community mental health team, service users and their supporters about their opinions of what the role should be. In addition I will also analyse relevant service and clinical documents related to the role and the process of care.

Do I have to participate?
No. Participation is voluntary, but it is important that you take part so that the study can get the best picture possible of the nurse’s role in practice. You may decide to withdraw from the study at any time.

What if I do not participate?
If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you had before entering the study. Should you decline to take part in the study or decline to answer any questions during the study, your decision will be respected. You will not be asked for an explanation of your decision.

What will involvement entail?
You are asked to be involved in the second part of the study. This component of the study will focus on the delivery of care in practice, and run over an 18-month period. It must be emphasised at this point that service users are not the subject of this ethnography. In the initial part of the study, I want to shadow nursing members of the team and observe them in the
process of care with service users with a medical diagnosis of schizophrenia. The purpose of this phase is to allow the researcher to develop an understanding of the care process used in contemporary practice. For the remainder of the study (approximately 15 months), I will work alongside you as a member of the community mental health team and carry a caseload. Throughout the eighteen months I will keep field notes of my work. These are to help me remember my observations; keep a record of the care I give and of my research work. The observations will subsequently form part of the final analysis of the study. These notes will not contain any of your personal details. To protect your identity you will only be identified as a case number. If you do agree to participate in the study and change your mind later there is no problem. Your decision will be respected and no notes or observations will be made concerning you. If you do not want to be included or made reference to in any of the observational notes collected this will be respected fully.

If you agree to be observed working with service user I will also need to obtain consent from the service user. Prior to you engaging in any clinical activity I would ask you to introduce me to the service user and I will explain the reason for my presence, the nature of the study. He or she will be informed that they can ask the researcher to leave at any point in time, without needing to provide a reason. The researcher will leave immediately if the service user does not agree to him being there, or is requested to do so at any time. The service user can then give verbal consent as to whether I can stay & observe.

What will involvement in the interviews entail?
In addition to your involvement in the non-participant-observation part of the study, you may be asked to participate in an interview. I hope to conduct approximately 20 interviews with members of the community mental health team and recipients of the service (service users and families) to get their perceptions of what the role should be.

You may be asked to be interviewed. If you agree to be interviewed I expect it to take about 60 minutes. I will hold the interview at a time and location that suit you. If you agree to be interviewed, I would like to audio-record the interview. This is so I can listen to it afterward, to ensure that I represent your views as completely as possible. Once the interview is over, I will write it as a transcript. You may have access to the transcript and the audio-recorded interview afterwards if you wish. The recording and any subsequent printed transcripts will be kept safely in a locked press. At no stage will your name appear on the interview tape or the transcript. Each recording and printed transcript will be given a number for identification purposes.

Over the course of the study any information transferred to a computer will be password protected.

Will I get any benefit from being involved in the study?
There will be no direct benefits to you, but I hope that your input will have an indirect impact by improving the quality of care.

Are there any reasons why I will not be able to take part?
You cannot take part if you are under 18, if you are not a member of the community mental health team or you do not consent to being involved with the study.

Will anybody know that I was involved in the study?
No. I will not tell anyone that you were involved in the study. I will not use any information that might identify you. If you wish to talk to people about the study, you are free to do so. However, I must let you know that if during the interview you tell me something about unprofessional practice, then I must tell this to the relevant personnel. Should this happen, I will let you know, but I must point out that I do not need your consent to pass on the
information. It is rare that this may happen, but if it does I cannot assure complete confidentiality.

The study was granted ethical approval by the Ethics Committee in the Faculty of Health Sciences in Trinity College Dublin.

Funding: The study is being funded by (should funding be received this will be acknowledged).

If you need any further information or if anything is not clear, I will be happy discuss any of this information with you. You can contact me at 01-XXXXXXX or you can also contact me by e-mail: XXXXXXXX@tcd.ie.

How do I take part?
If you want to take part fill in the sheet with this form asking me to contact you. Please make sure that you have put your name and a contact details on the sheet. If you have a time that you want me to contact you, put this down too. Send the form back to me in the stamped addressed envelope and I will contact you to discuss the research further.

Thank you for taking time to read this leaflet, and for considering taking part in this study.
Appendix 3: Participant Consent Form (CMHT Observation)

INFORMED CONSENT FORM (CMHT Observation)

PROJECT TITLE:
The psychiatric nurses' role working with people with the medical diagnosis of schizophrenia

PRINCIPAL INVESTIGATOR: MARK MONAHAN

BACKGROUND
The purpose of this study is to create an understanding of the role of the psychiatric nurse working with people with a medical diagnosis of schizophrenia, in contemporary Irish mental health practice. The study aims to identify the beliefs, values, knowledge and skills that psychiatric nurses need to increase the effectiveness of their practice.

I understand that during this phase I will be accompanied and observed by the researcher during my interaction and provision of care when working with people with a medical diagnosis of schizophrenia. These observations will be recorded by the researcher in the form of field notes which will subsequently form part of the final analysis of the study. I understand that participation in this study is voluntary and that I may withdraw at any time. If I decide not to participate, or if I withdraw, I understand that I will not be penalised and will not give up any benefits that I had before entering the study.

DECLARATION
I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement

PARTICIPANT'S NAME: .................................................................

CONTACT DETAILS: .................................................................

PARTICIPANT'S SIGNATURE: .....................................................

DATE: ..................................

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE: ...............................................

DATE: ..................................

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Appendix 4: Letter to Service User (Key worker)
The psychiatric nurses' role working with people with the medical diagnosis of schizophrenia

School of Nursing and Midwifery
Trinity College Dublin
24 D'Olier Street
Dublin 2

Date xxxxxxx

Dear Service User

'Schizophrenia' is often perceived as a threatening word and for many it is linked with a life of misery, isolation, and torment. This should not and need not be the case. Our understanding of the diagnosis of 'schizophrenia' is changing. We now see a way whereby, with sensitive supports people can achieve a life full of creative work, love, and friendships. Psychiatric nurses are a key group in providing care in schizophrenia. However, it is acknowledged that the role of the psychiatric nurse in care needs to change.

I am a Registered Psychiatric Nurse and a Doctoral student at the School of Nursing & Midwifery in Trinity College Dublin and I am conducting a study to develop greater understanding of what that psychiatric nurse's role should be.

I am asking you to participate in this study. The results study will hopefully improve the quality of care for people with a diagnosis of schizophrenia. Participation in the study is entirely voluntary.

Please find attached a detailed information sheet about the study and what it involves if you are willing to participate. I have a lot experience working with people with a diagnosis of schizophrenia. If you wish to know more please fill in the form and return it in the stamped addressed envelope provided. I will arrange a time that suits your to discuss your possible involvement in more detail. If you have any questions, please do not hesitate to contact me at 01-XXXXXXX.

All your responses will be treated in strict confidence. I hope that you will support and be involved in this important study.

Yours sincerely,

Mark Monahan
Appendix 5: Information Sheet for Service User Participants (Keyworker Relationship)

THE PSYCHIATRIC NURSES’ ROLE WORKING WITH PEOPLE WITH THE MEDICAL DIAGNOSIS OF SCHIZOPHRENIA

Name of researcher: Mark Monahan

What is the study about?
This study will look at the role of the psychiatric nurse working with people with the medical diagnosis of schizophrenia. This study will try to find out what psychiatric nurses need to improve practice. The results should provide help establishing what is needed to develop staff and educational programmes psychiatric nurses in the future.

Do I have to participate?
You do not have to participate. Participation is voluntary, but it is important that you take part so that the study can get a picture of the opinions of service users/family/supporters (delete as appropriate) on what you believe the role should be. You may decide to withdraw from the study at any time. My possible allocation as your keyworker was made in conjunction with your consultant psychiatrist and the other members of the community mental health team.

What if I do not participate?
Participation, non-participation or withdrawal from the study will not affect you or the service you receive in any way.

What does the study involve?
If you take part in the study, I will act as your keyworker during your contact with the service. I am a registered psychiatric nurse with over twenty years’ experience working with people with a diagnosis of schizophrenia. I will work alongside the other members of the community mental health team in exactly the same way as the other psychiatric nurses on the team. You can request a new keyworker at any time without needing to provide a reason and you will not suffer any negative consequence in terms of care they are given. To help me remember the care I give I will keep a record of my work in my personal diary. These notes will not contain any of your personal details. To protect your identity you will only be identified as a case number. If you do agree to participate in the study and change your mind later there is no problem or if you do not want to be included or made reference to in any of the observational notes collected this will be respected fully.

Are there any risks involved?
I do not foresee major risks from you being involved in this study. Please be assured that at all time, your wellbeing will take priority over the study. The care that I will provide will be the care approved by the community mental health team, and will not be different from other similar service users.
Will I get any benefit from being involved in the study?
There may be no benefits to you directly outside of the normal care that you receive, but I hope that your involvement will have an indirect impact on improving the quality of care for service users in the future.

Are there any reasons why I will not be able to take part?
You cannot take part if you are under 18 or you do not consent to being involved with the study.

Will anybody know that I was involved in the study?
Only the members of the community mental health team responsible for your care will know. I will not use any information in the study that might identify you. However, if you wish to talk to people about the study, you are free to do so. However, I must let you know that if during our work you tell me something about unprofessional practice, then just like other members of the team I must tell this to the relevant personnel. Should this happen, I will let you know, but I must point out that I do not need your consent to pass on the information. It is rare that this may happen, but if it does I cannot assure complete confidentiality.

The study was granted ethical approval by the Ethics Committee in the Faculty of Health Sciences in Trinity College Dublin.

If you need any further information or if anything is not clear, I will be happy to discuss any of this information with you. You can contact me at 01-XXXXXXX or you can also contact me by e-mail: XXXXXXXX@tcd.ie.

How do I take part?
If you want to take part, fill in the sheet with this form asking me to contact you. Please make sure that you have put your name and a contact details on the sheet. If you have a time that you want me to contact you, put this down too. Send the form back to me in the stamped addressed envelope and I will contact you to discuss the research further.

Thank you for taking time to read this leaflet, and for considering taking part in this study.
Appendix 6: Informed Consent Form (Keyworker)

PROJECT TITLE:
The psychiatric nurses’ role working with people with the medical diagnosis of schizophrenia.

PRINCIPAL INVESTIGATOR: MARK MONAHAN

BACKGROUND
The purpose of this study is to create an understanding of the role of the psychiatric nurse working with the medical diagnosis of schizophrenia in contemporary Irish mental health practice. The study aims to identify the beliefs, values, knowledge and skills that psychiatric nurses need to increase the effectiveness of their practice.

I understand that participation in this study is voluntary and that I may withdraw at any time. If I decide not to participate, or if I withdraw, I understand that I will not be penalised and will not give up any benefits that I had before entering the study. Being part of the study will involve me permitting the researcher to act as my keyworker for the period of the study (up to one year). I understand that my keyworker relationship will be maintained in the same manner as my existing care arrangements.

DECLARATION
I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT’S NAME: .................................................................

CONTACT DETAILS: .................................................................

PARTICIPANT’S SIGNATURE: ......................................................

DATE: ........................................

Statement of investigator’s responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR’S SIGNATURE: ..................................................

DATE: ...............
Appendix 7: Field note extracts
Field note 09.01.14 Phone conversations

Looking at the phone conversation on Friday evening it was very interesting to look at the dynamics of what happened in the exchange.

X was quite aggressive in her tone and approach. She was very polite and courteous. This was a client who was not attending for his prescription and did not want from her perspective to take responsibility for his condition. The whole experience appeared like being read the riot act. This was the third or fourth occasion that he had done this. The tone did not correspond to the body language or facial expression at the end of the conversation. It was difficult to know if it was genuine concern or an attempt to reduce the workload.

I am not sure how the service user would view this conversation. In his action he has chosen to disregard what advice he is being given about his condition his repeated failure to collect his medication, clozaril, indicates a reluctance to comply with the regime. Has anybody asked why? There appears to be an implicit adherence to medical model thinking. The role exhibited appears an extension of surveillance and control. Is this something that I can live with? If this is to be my ultimate contribution will I be able to live with it?

This is the predominate intervention that I have seen so far. Must I accept this role in the time allocated? It will be the consultant’s expectation that this will be the primary expectation. From what I have seen so far the prerequisite intervention in psychosis is pharmacological. The question I must now answer is why. Is this because of resources or because of effectiveness or because of deficiencies in the knowledge base? Or what?

Field note 09.03.05 XXX v YYYY

This is an interesting perspective that emerged in the discussion on the format of the case conference. Within this environment possibly up to 20 people may be present to discuss each client’s care. YYYY was troubled with this perceived power imbalance within the care relationship and the manner in which made it an inequitable one. I commented on this with XXX, on the way that this might occur. XXX was initially apprehensive with YYYY’s interpretation of the dynamics of the team meeting. He initially thought that what I was talking about was the absence of the service user in the forum. He recounted the experiences working with another team where the team discussion happened with the service user present. He reflected on a true inequity within this event. I tried to explain that it was not the presence or absence of the person that YYYY was talking about but rather the imbalance that 20 professionals decide on one person. XXX found solace in an alternate view. Here we have a situation where a wealth of experience and resources were being directed for the benefit of the person. Who’s view is right?

Field note 09.03.31 Psychoeducation

It was very interesting to see how the psychoeducation group developed over the past two weeks. After the very heavy session on stigma and prejudice where I felt that I lost control of
the group a bit in allowing more open discussion the third and fourth groups have run exceptionally well. There has been a falloff in numbers from the initial 17 to a core group of 8 or 9. Time is a huge factor. People have become so engrossed in discussion that they were prepared to forego tea just to keep talking. Only one of the group is a new diagnosis. I felt initially that the experience for her would be so overwhelming that she would have ran away. I had spent a long time with her after the first session answering her concerns. She now appears to be learning from a positive experience despite some of the most horrific stories from the more senior members. It appears to be that even the smallest things appear to give hope and despite some people coming having heard it all before that there is something new to be found in each session.

Field Note 09.09.11 Whose agenda?

XXXXXXXXX appears happy that I am thinking about the approach that I might use with YYYY. She talks in terms of plans and experiments that we might develop. I want to be very open in what might be happening. I am a little confused about what she said about what he was doing with her today. He wanted to talk about the experiences. This she seemed to think might be related to the lowering of medication and him not taking it.

"That may be you're agenda and you may have it worked out in you're head but it may not be his". ZZZZZZ's response after my first formal meeting with YYYY.

Field Note 09.10.05 Is it or isn't it?

Working with XXXXXXX proved to be a much more liberating experience with the comfort that the diagnosis brought. It gave a reference framework and a comfort rather than trying to avoid the s word all the time. It placed we in a place where my knowledge could. Be brought to bear on fixed areas. It did not matter whether the person had bought into the concept or not I was in a position to normalise the experiences it did not become a barrier. I could place the experiences in context. This is the first occasion where the diagnosis has been upfront. The funny thing is it was not this service that gave the label it came from a private institution. The service is happy to use it in this situation. I am happy to use it too.

I am dealing with the same issues and approaches with iob yet the diagnosis is not there. Similar problems are present. The same medications are used. Similar thought processes exist.

The same precipitants are there but the diagnosis is in a much greyer domain. XXXXXXX encounters similar issues. Now his decision is to reduce medication and we are kicking in the MHA to prepare the family for a major episode.

When I return to this case XXXXX asks me or tells me that he will be interested in my take. He is not convinced by the private psychiatrist's diagnosis of schizophrenia he is leaning more to his own formulation of personality traits.
I visited XXXXXXX myself on Friday and we discussed his current state. I outlined where we felt the course of DBT might help but he was not convinced by either diagnosis. His conviction was the need for a change in medication. He listed symptoms of his head exploding and of recurrent inner tension. All of which did not respond to medication but he still wants a new one. When I examine his case file today these are the very same symptoms that he presented with five years ago before any diagnosis of psychosis was considered. What difference did either diagnosis make. On the last occasion he admitted to faking symptoms but he considers on this occasion they are real. He contacted me when I was off duty on Friday evening. He had now presented to his GP who directed him to casualty in XXXXXXX. His father did contact the service to see if it was necessary and was quite distressed almost tearful. His presentation does not seem typical of schizophrenia. His desire for company and more social lifestyle is at odds with what you would generally expect. His academic achievement being high and his desire for a first, I do not think fit with my general notions. At heart I find the diagnosis hard to believe. This diagnosis is very much the complete opposite of YYYYYYY’s case. One reluctant to take treatment despite the distressing nature of his experiences the other in pursuit of a diagnosis and willing to endure large volumes of anti-psychotic medication in face of a need for a label.
Appendix 8: Interview extract
<table>
<thead>
<tr>
<th>Time</th>
<th>Interview Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>27:07.4 - 28:34.1</td>
<td>Interviewer: well start at the top, you had said that you had told about what I had said to you and you felt you had some ideas, and don't think about this has an interview think about it as a conversation between you and me</td>
</tr>
</tbody>
</table>
| 28:34.0 - 29:04.5 | Interviewee: you see like the nurses are very good but I have had an experience like with B do you know B...  
Interviewer: yes...  
Interviewee: well basically like I was on Depixol for a few weeks, will I read this out, when I read this out?  
Interviewer: fire away whatever works for you...  
Interviewee: well I was in bed for a few weeks because I had got a Depixol, this was like about a month ago |
| 29:04.9 - 30:41.2 | Interviewee: I was frozen, I couldn't move, I was pressing my teeth together and emh... and like...oh sometimes...Jesus...I was pressing my teeth together...emh...I was having all of these symptoms and they wouldn't give me Kemadrin...  
Interviewer: ok:...  
Interviewee:...so I was shaking and stuff in the hospital and everybody said that I looked fine but really I wasn't because I was like shaking and stuff. I did not feel good inside I felt very vulnerable and stuff, like I could not cycle my bicycle anywhere because I was afraid I would fall off or be hit by a car or something and then for two weeks like I was sick in bed anyway and like I rang up...like so I really want to do a good job her like...but it is wierd, you need to be careful what you say  
Interviewer: you don't have to be careful about what you say...  
Interviewee: really, ok...  
Interviewer: you can say, and what I would really like is for you to tell me exactly how you feel about this...  
Interviewee: ...ok...  
Interviewer: like really like if I can put it to you this way you can think about trying to sanitise this and make it sound as though everything is wonderful and such being the case I can go back and tell people actually everything is wonderful...  
Interviewee: yes, that is why I if I don’t want to complain... |
| 30:41.1 - 31:51.7 | Interviewee: well I guess I just feel like the nurses are really busy and they seem to be overworked, a little bit...because emh...I ...ok I will go back to the Depixol thing |
Interviewer: ok

Interviewee: well I phoned up B just saying that I was sick, whatever, and she was giving out to me on the phone and stuff and I felt she was letting her stresses get to me and I was already stressed out because I was on the Depixol and I was like panicking because at first the Depixol was making me hyper ... so emh... I keep thinking about the tape, the Depixol was making me hyper and everybody thought I was doing really well so I think people were blanking me a little bit, some of the nurses...

Interviewer: ok

31:51.6 - 32:55.5 Interviewee: so I don’t want to be criticising the nurses because they do such a good job and emh it is just like,

Interviewer: Do you think they weren’t believing you? It sounds as though you were having adverse effects...

Interviewee: yeah, well I was having really bad side effects on medication and I felt terrible and they ...emy... they were doing their best like ...emh...I do not perform well under pressure really (both laugh) so ok...so I was like shaking and stuff and everyone, they thought I was fine, but even when I was on the Clozaril, and I collapsed on the Clozaril, there was no one who believed, and they did believe that I collapsed like, but they didn’t see it, they have to see it to believe it...

Interviewer: yeah...

32:55.4 - 34:32.1 Interviewee: so I would like...anywhere it is a place to go where you feel relaxed and you can get away from everywhere else, and where people are really nice but it is still like I could just say I have no complaints like you know it could just be the mood you are in and like they do believe me that I was collapsing there because they do say I can’t go on Clozaril, this is Dr. Z as well like, they say I cannot go on Clozaril, but the nurses just do what they tell them to do, really so, the nurses do their best like and they work as a team, and they are really good, like with B, I was in bed for two weeks and I couldn't move and I asked B to get my sleeping tablets for me so if I don’t sleep and I stay awake and I go crazy like, I am awake for the whole of the night I just feel it overwhelms your mind like, so I didn't have any sleeping tablets and I asked her to go to the chemist and get sleeping tablets for me and bring them up to me, I know it is kinda, I was in bed like, I couldn't move like, she said that she can't do it and this was the weekend I think, and she said that she cant because she said that she just couldn't do it, so I had to cycle down myself, and get the sleeping tablets, so, and then like I rang up as well and I was like under pressure and stuff and I wasn't feeling very well and she was like loosing her temper with me as well...

34:32.1 - 34:33.1 Interviewer:.... ok...

34:32.9 - 36:16.2 Interviewee: ...and I really felt her stress rubbing off me like, and on Wednesday when I came in the nurses are really busy like, but they do their
best like, but they do a really good job like but I think they are just too busy, like, I was just stressed out and when I came in they were walking around doing work for other people and then like C didn’t give me her phone number either, and D used to give me her phone number and bring me out for coffees and stuff, like I have it here I will just read it out, so I was in bed for two weeks with the reaction ... let me see ... emh... yeah, well you see there is stuff about the psychiatrist as well like...

Interviewer: yes...

Interviewee: and there is no point about talking about that...

Interviewer: ... if you want to...or perhaps if you would not mind would you let me take a copy of that...

Interviewee: ... of these... I am having trouble reading my own writing (laughs)...

Interviewer: I have spent 30 years reading doctors writing...

Interviewee: ... and that is scribbles... so ... ok...

Interviewer: it is just if it helps...

Interviewee: yes, I don't mind, I knew I might struggle that is why I wrote it down, I knew when I had the tape I would not be able to like relax, and I want to make sure I put everything down...

Interviewer: What I can do maybe, with stuff I cannot understand if I come back to you on it...

Interviewee: Yeah ok...

Interviewer: Bye and large I can make sense of a lot of things

Interviewee: Ok, well ... I was in bed for two weeks and it was given to me on a Thursday and it lasted for two weeks but I asked to be lowered to twenty five because I was on 10 and I moved up to twenty and they put me on thirty and I was really hyper and I could not relax so I felt like it was too much like I was just keeping busy all of the time, so I was taking Inderal, then I stopped taking Inderal so they wanted me to take Inderal and I stopped taking that, and I sweated away and it could be the weather, and I felt restless and I was getting into arguments with my family because it made me real hyper and I wanted to keep doing things and I think it was also because I was applying to NCAD at the same time...

Interviewer: Ok...

Interviewee: so emh... I was excited by that so I was moving around a lot but I also felt with the Depixol is that it is a little bit of an anti-depressant
so it was making me happy, like, too happy so then I wanted to lower it to twenty five and I was on thirty and Dr. K. said that I could, and but then Dr. Z said that forty was the therapeutic dose, so I would relax more on the forty and he was right like, and I am more relaxed, so then they highered it more to forty so that it would eliminate the questions whether it would work or not because if I would know on forty ... so I agreed to do it and any, and Mary is great, like she does not do anything wrong, so then like, now I feel more relaxed, though after going on the forty like, but at first I was in bed, so I was in bed sick every hour was hell and I thought that I would get through it. I needed phonecalls constantly and the phone bill came to €86 in bills in phonecalls, so I was making a lot of phonecalls like and Dr. Z didnt give me any Kemadrin, and as the weekend came I was shaking and I didnt get any sleep on Sunday night, so I phoned Lakeview on Sunday, next day I was shaking I had a stiff neck, brain was frozen I felt very vulnerable, overtired as I had no sleeping tablets, they said they had seen no side effects in me, so they gave me Valium though, but they said they had seen no side-effects in me... I never felt so bad in my life, so shaky, so I survived the two weeks and they gave me the injection, and you know the way you have to take the medicine for up to two weeks after, so I took the injection, the forty, and they did not give me Akineton, or kemadrin so then ...emh I ... so I feel a bit bad about repeating this...

Interviewer: the thing is you have needs...

Interviewee: at the time if you had talked to me I would have complained about it, but because I am too preoccupied now because I have gone on with my life, now it is hard to refer back, because the Depixel just makes me stupid in a way as well, because with the Akineton I just can't think, so I don't think (laughs)

Interviewer: I don't think so...

Interviewee: so I survived the week, they gave me a bit of Valium, why did they give me Valium, whats this there...so why did they give me Valium and say they did not see any side-effects

...emh... next weekend I was shaking, my mam was away on holidays and she came back, and I went to ... (out of hours GP service) and the Dr. there said that I needed to go to Meadowfield to see a psychiatrist. My dad would not give me a lift, so she gave me akineton, and I felt better, my mam came back as well, so I felt more relaxed, and she said I need to go to Meadowfield to see a psychiatrist (rereading story), and the pharmacy was closed so the next day my mam went down for me the next day, and my mam went down for me and got the Akineton, and it got rid of my stiff neck and foggy brain, I asked, this is the thing with B, I asked B to get me a sleeping tablets for the weekend as I was in bed, I felt debilitated, and she said she would not bring them to me so I had to go down ...emh... B... emh... so I had to go down and get some tablets, B works hard but she loses control of her temper, because she is letting... she is too overworked or something, so at that point I think that the nurses should be strong for you
like, because Angela was very strong and she would never let her personal life get in the way, she was very positive person, and she still is but she is gone from here but emh... emh...

I will go back to the 14th now ... right... so that was the Depixol that was when I was on the Depixol, I forgot to get my sleeping tablets one day, and ...emh I couldn't sleep so I felt crazy......neighbours... so then neighbours...I phoned Meadowfield and they said I would be looked after if I go to Rathmullen ... (low voice reading)... so feeling sleepy ... no this is when I started, this is when... I read these already today...so I was I couldn't sleep like, because of the depixol so I phoned Meadowfield and they said I would be looked after if I go to Rathmullen so feeling sleepy but I was aroused because I was wide awake, and I didn't want to get an ambulance so I paid for a taxi, I was unwell, kept talking, even though I was tired, yeah, I was talking to the taxi driver even though I was really knackered like, I went to A+E, but that is really not about the nurses though..

Interviewer: No, not specifically...

Interviewee: no you see the nurse, you see I actually phoned up when I could not sleep, Rathmullen Hospital, when it was 4am in the morning and I was awake the whole night and I could not sleep

so they said that I should wait until the next morning, but you know it is really annoying for me to be awake at night because I feel like I am crazy the thing is I wasn't like that before, I am getting worse like and then ...emh... so I phoned up anyway I phoned up and they said 'drink some milk' and they were really friendly, but then the third time I phoned, this woman F or whoever she was like saying well, just go to bed, and she was being grumpy-like, because it was the middle of the night, so she was tired like and stuff, so what am I supposed to do? Am I supposed to say well she is tired even though I am the one who is the patient, and it was the weekend as well, and I think ...emh like when it is the evening time I cannot do anything...because the nurse is working during the day, like I mean Shannon, Angela and Peter and Mandy, they are all very nice people because they are actually good people and they like, but B was very... like she couldn't handle the work load like. Maybe she was over worked or something downstairs, now Mandy she is coming back, Mandy is very good, because with Mandy, when I used to come in she used to tell me to come in at ten in the morning every day and she would give out to me, pleasantly, not in a bad way, she would say come in every day at ten to make me get used to getting up like...

Interviewer: Routines...

Interviewee: yeah... now B doesn’t do that, and G, G is very quiet as well, and they dont put much effort in, but B puts more effort in but she did lose her temper
Angela because I could not sleep and I was going through a bad time so Angela was around Rathmullen and I was phoning Angela and B was giving out to me because she said I have to leave Angela alone, B did not know that I knew Angela for five years and it was not easy just to stop talking to Angela. So then ...emh so B was giving out to me about that and then she said that if I have any complaints just complain about he, well she didn't say that exact words but that was the impression that I got and emh, I don't know what it is, I don't know if she is happy or not, because when she says something like that 'complain about me I dont care' it is obvious that she cannot handle the workload and she cannot handle me, whatever, but emh... then I explained to B that I knew Angela for five years and she was supposed to see me for like a few weeks before...

Interviewer:... a transition...

Interviewee: yeah, like, yeah so then  emh

Interviewer: Did you come to rely on Angela a lot?

Interviewee: Yeah but I don't know if that is a good or a bad thing, because that is the thing, like I think in anything in life if you know someone too much, the thing has stopped, and B rang me up and apologised like because she said that ...emh...she didn't know that I was supposed to see Angela for a few weeks but I think that is harsh anyway that she said that I cannot phone her, but then Angela is very good, like I would phone her and she was not working some times like once I was feeling suicidal on a Sunday and she came out to my apartment like and was looking for me, and emh, so emh, so she really put her time into it, it was like having a second mom, like and stuff...
Appendix 9: Letter to Service User (Interview)
The psychiatric nurses’ role working with people with the medical diagnosis of schizophrenia

The psychiatric nurses’ role working with people with the medical diagnosis of schizophrenia

School of Nursing and Midwifery
Trinity College Dublin
24 D’Olier Street
Dublin 2

Date xxxxxxxx

Dear Service User

‘Schizophrenia’ is often perceived as a threatening word and for many it is linked with a life of misery, isolation, and torment. This should not and need not be the case. Our understanding of the diagnosis of ‘schizophrenia’ is changing. We now see a way whereby, with sensitive supports people can achieve a life full of creative work, love, and friendships. Psychiatric nurses are a key group in providing care in schizophrenia. However, it is acknowledged that the role of the psychiatric nurse in care needs to change.

I am a Registered Psychiatric Nurse and a Doctoral student at the School of Nursing & Midwifery in Trinity College Dublin and I am conducting a study to develop greater understanding of what that psychiatric nurse’s role should be.

I am asking you to participate in this study. The results study will hopefully improve the quality of care for people with a diagnosis of schizophrenia. Participation in the study is entirely voluntary.

Please find attached a detailed information sheet about the study and what it involves if you are willing to participate. I have a lot experience working with people with a diagnosis of schizophrenia. If you wish to know more please fill in the form and return it in the stamped addressed envelope provided. I will arrange a time that suits your to discuss your possible involvement in more detail. If you have any questions, please do not hesitate to contact me at 01-XXXXXXX.

All your responses will be treated in strict confidence. I hope that you will support and be involved in this important study.

Yours sincerely,

__________________________

Mark Monahan
Appendix 10: Information Sheet for Service User (Interview)

THE PSYCHIATRIC NURSES' ROLE WORKING WITH PEOPLE WITH THE MEDICAL DIAGNOSIS OF SCHIZOPHRENIA

Name of researcher: Mark Monahan

What is the study about?
This study will look at the role of the psychiatric nurse working with people with the medical diagnosis of schizophrenia. This study will try to find out what psychiatric nurses need improve practice. The results should help establish what is needed to develop staff and education courses for nurses in the future. You are invited to participate in an interview to provide your perspective on what you think the role should be.

Do I have to participate?
No. Participation is voluntary, but it is important that you take part so that the study can get a picture of the opinions of service users/family/supporters (delete as appropriate) on what you believe the role should be. You may decide to withdraw from the study at any time.

What if I do not participate?
Participation, non-participation or withdrawal from the study will not affect you or the service you receive in any way.

What does the study involve?
If you take part in the study, I will interview you. I am a registered psychiatric nurse with experience in working with people with a diagnosis of schizophrenia. I will visit you in your home and ask questions about what you think the nurses' role should be. The interview is expected to take about 60 minutes. If you agree to be interviewed, I would like to audio-record the interview. This is so I can listen to it afterward, to ensure that I represent your views as completely as possible. You may have access to the transcript and the audio-recorded interview afterwards if you wish. Once the interview is over, I will write it out on paper.

Are there any risks involved?
There are no major risks involved in this study. However, I am aware that you may become upset when talking about your or your family experience. Should this happen when discussing your experiences I will stop the interview and I will provide some time for you to talk about your feelings. I will only continue if you think that it is not going to cause you any further upset. You may stop the interview at any time.

Will I get any benefit from being involved in the study?
There may be no benefits to you directly, but I hope that your input will have an indirect impact on improving the quality of care.

Are there any reasons why I will not be able to take part?
You cannot take part if you are under 18 or you do not consent to being involved with the study. You cannot participate if medical and nursing personnel think you are not able to give consent or if the researcher has been your keyworker.

**Will anybody know that I was involved in the study?**

No. I will not tell anyone that you were involved in the study. I will not use any information that might identify you. If you wish to talk to people about the study, you are free to do so. However, I must let you know that if during the interview you tell me something about unprofessional practice, then I must tell this to the relevant personnel. Should this happen, I will let you know, but I must point out that I do not need your consent to pass on the information. It is a rare that this may happen, but if it does I cannot assure complete confidentiality.

The study was granted ethical approval by the Ethics Committee in the Faculty of Health Sciences in Trinity College Dublin.

If you need any further information or if anything is not clear, I will be happy discuss any of this information with you. You can contact me at 01-XXXXXXXX or you can also contact me by e-mail: XXXXXXXX@tcd.ie.

**How do I take part?**

If you want to take part fill in the sheet with this form asking me to contact you. Please make sure that you have put your name and a contact details on the sheet. If you have a time that you want me to contact you, put this down too. Send the form back to me in the stamped addressed envelope and I will contact you to discuss the research further.

Thank you for taking time to read this leaflet, and for considering taking part in this study.
Appendix 11: Informed Consent Form (Service User Interview)

PROJECT TITLE:
The psychiatric nurses’ role working with people with the medical diagnosis of schizophrenia.

PRINCIPAL INVESTIGATOR: MARK MONAHAN

BACKGROUND
The purpose of this study is to create an understanding of the role of the psychiatric nurse working with people with a medical diagnosis of schizophrenia, in contemporary Irish mental health practice. The study aims to identify the beliefs, values, knowledge and skills that psychiatric nurses need to increase the effectiveness of their practice.

I understand that participation in this study is voluntary and that I may withdraw at any time. If I decide not to participate, or if I withdraw, I understand that I will not be penalised and will not give up any benefits that I had before entering the study. The interview will be audio recorded to ensure my views are represented as completely as possible. Being part of the study involves me giving my views and opinions on the nurses’ role. During the interview, I will be asked some open-ended questions, which I am free to answer in whatever way I choose. If I wish access to the recording or to see a copy of the interview after it has been transcribed I can contact Mark Monahan at XXXXXXXX@tcd.ie or 01 XXXXXXX.

DECLARATION
I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT’S NAME: .................................................................

CONTACT DETAILS: .................................................................

PARTICIPANT’S SIGNATURE: .....................................................

DATE: ................................................

Statement of investigator’s responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR’S SIGNATURE: ...................................................

DATE: ..................
Appendix 12: Mitchell’s (1991) Questions

What is the setting of the action? When and how does action take place?

What is going on? What is the overall activity being studied, the relatively long-term behaviour about which participants organize themselves? What specific acts comprise this activity?

What is the distribution of participants over space and time in these locales?

How are actors organized? What organizations effect, oversee, regulate or promote this activity?

How are members stratified? Who is ostensively in charge? Does being in charge vary by activity? How is membership achieved and maintained?

What do actors pay attention to? What is important, pre-occupying, critical?

What do they pointedly ignore that other persons might pay attention to?

What symbols do actors invoke to understand their worlds, the participants and processes within them, and the objects and events they encounter? What names do they attach to objects, events, persons, roles, settings, equipment?

What practices, skills, stratagems, methods of operation to actors employ?

Which series, motives, excuses, justifications or other explanations do actors use in accounting for their participation? How do they explain to each other, not to outside investigators, what they do and why they do what?

What goals do actors seek? When, from their perspective is an act well or poorly done? How do they judge action -- by what standards, developed and applied by whom?

What rewards to various actors gain from their participation?

## Appendix 13: Treatment and Care Plan

### TREATMENT AND CARE PLAN FOR:

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Comment and Action</th>
<th>By whom</th>
<th>Priority rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health (Assessment, treatment and monitoring of psychiatric symptoms, medication side-effects)</td>
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<tr>
<td>Personality function (e.g. impulsivity, frustration, intolerance, aggression, mood lability, sexual issues)</td>
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<tr>
<td>Communication/ cognitive problems (language, cultural, memory/conc.)</td>
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<td>Substance misuse</td>
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<td>Engagement (insight, medication management, commitment to treatment plan)</td>
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<td>Physical health/disability/weight:</td>
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<td>Support Network (family, social, professional etc.)</td>
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<tr>
<td>Financial issues (debt management, benefits etc.)</td>
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<tr>
<td>Occupational/vocational/leisure needs</td>
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<tr>
<td>Self-care/A.D.L.s</td>
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<tr>
<td>Risk assessment and crisis planning</td>
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<tr>
<td>Carer needs (e.g. partner, children):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Unmet needs:
- Patient:
- Partner/children:

<table>
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<tr>
<th>TCP level</th>
<th>Date of review</th>
<th>Arranged by:</th>
</tr>
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<td>Patient:</td>
</tr>
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<tr>
<td>2</td>
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<td>Consultant:</td>
</tr>
<tr>
<td>3</td>
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<td>Key worker:</td>
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</tbody>
</table>

Date: Signed by:  

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