Northumbria Research Link

Social network meetings in an acute psychiatric setting:
A practitioner research enquiry

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A thesis submitted in partial fulfilment of the requirements
of Northumbria University for the degree of Doctor of
Philosophy

School of Health, Community and Education Studies

July 2003

Abstract

Examination of the literature suggests that relationships between psychiatric staff and the families of service-users are often characterized as unsatisfactory, and that psychiatric hospitals provide an unconducive environment for the implementation of family and network-orientated approaches. This research focused upon the development in an adult psychiatric admissions unit of family-staff network meetings, that occurred when a person entered hospital. These network meetings, or 'reception meetings', were strongly influenced by the Finnish social network approach (Seikkula, Alakare & Aaltonen 2001), which focuses upon the creation of open dialogue between the service-user, family members and professionals. An overall aim of the study was to generate a body of practice-based narrative accounts which might act as a catalyst to practice developments in this field.

Drawing upon a postmodern methodological framework, a range of methods were employed to engage with the multiple voices of service-users, family members and staff in the research site. Data sources included semi-structured interviews, participant observation, secondary data, and material from a research diary that was maintained as a reflexive tool in relation to the practitioner research process.

A 'voice-centred relational method' (Brown and Gilligan 1992) provided a heuristic device for guiding data interpretation which facilitated multiple readings from different perspectives. A subsequent stage of data-analysis entailed developing more general connecting themes from across the data-set.

A number of themes are developed in the research, which principally relate to the tensions associated with the introduction of a relationally orientated, reflective approach to practice within an individually-based medico-psychiatric organizational context. Practice approaches are discussed which appeared to facilitate an ethos of 'safe uncertainty' (Mason 1993) within network meetings, which is a necessary condition for dialogue. Connections are also drawn between themes generated in this study and the broader contexts of government policy, professional and organizational development, and practice-based research.

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Acknowledgements

Authors declaration

I confirm that this work has not been submitted for any other award, and that it is solely my own work.

Alex Reed

Part one:

Contexts for the research

Chapter 1. Introduction to the research

This research explores a development in services for psychiatric in-patients and their families which was implemented within an adult mental health service in the North East of England. Psychiatric services have been criticized for maintaining a focus on the individual to the exclusion of the person's family or wider social network (Winefield & Burnett 1996), and a number of staff who were employed in this service wished to improve the help and support that families received when a relative was admitted to the hospital ward. The staff concerned were from different professional disciplines, and some also had training and experience in the field of family therapy. In 1997 this group of staff began to organize social network meetings at the point when a person entered the in-patient Unit. These meetings, known as 'reception meetings' within the organization, were attended by the service-user, their relatives or significant others, and members of the staff team. The purpose of the reception meetings was to create a forum in which dialogue could occur between these participants, and where information and ideas could be exchanged about how to progress the situation (Reed, Stevenson & Wilson 1998).

The introduction of these network or reception meetings within an in-patient psychiatric unit was a unique service development and there are no accounts in the literature of similar services in the UK. It was therefore an area of practice which was well suited to an exploratory, qualitative research approach. Qualitative methods are particularly useful for exploring specific social situations in depth (Denscombe 1998), and a qualitative design was therefore employed in this research with the aim of generating a rich and multi-voiced account of how the network meetings were perceived by participants, the ways in which they impacted on those involved (service-users, their significant others and staff), and the relationship between the meetings and the 'host' culture of the in-patient unit.

My position(s) in the research process

There is an increasing scepticism within the qualitative research field towards the idea of detached, neutral or value-free research (Gergen 1999). Postmodern conceptions of

knowledge have undermined the notion that it is possible to gain direct, unmediated knowledge about the world which is not contingent upon the social and historical circumstances in which it is arrived at. In other words, it is impossible to have a *"view from nowhere"* (Nagel, cited in Bruner 1990, p.14). For this reason, Steier (1991) recommends adopting a reflexive stance in relation to the research process by positioning ourselves as researchers inside, rather than outside of the field of inquiry.

My own relationship with the research setting was complex. At the time that the research proposal was developed and during the period of data-collection for the study I was employed as a senior nurse within service. In this post I held responsibilities for maintaining professional nursing standards in the in-patient Unit where the reception meetings were introduced. In addition, I am qualified as a family therapist, and together with colleagues from within this service had been involved in providing direct clinical services to families for several years. I was also part of the small group of staff who originally conceived of the idea of the reception meetings, and had worked hard with colleagues to get the project off the ground. I therefore occupied multiple, complex and potentially powerful roles in relation to the staff, service-users and families who participated in this research, and these multiple roles have inevitably shaped the research process in significant ways.

For these reasons, it is important for me to declare from the outset my own commitment to the clinical work which is examined in this research. Together with the colleagues who participated in the reception meetings project, I was motivated by a wish to improve practice, rather than by a more neutral aim of generating knowledge about the phenomenon for its own sake. Because of my background in family therapy I was particularly keen to see the spread of services for families within the Unit, and to explore how concepts and practices from the systemic field which is primarily concerned with understanding problems within a relational context could be applied usefully in this particular organizational setting where more reductionist, biologically orientated theories tend to predominate (Johnstone 2002).

In line with ideas from the field of action research (Waterman 1995) and practitioner research (Reed & Procter 1995), my aims in undertaking the project were therefore twofold: both to generate theory which is potentially applicable in this field, but also, and no less importantly, to facilitate the development of practice. A number of writers have called for a

blurring of the boundaries that are sometimes seen to exist between the domains of research and practice (Rolfe 1998; Shotter 1993) and for the development of research approaches in which the researcher is actively committed to organizational or social change (Lather 1986).

Rationale for practitioner research design

The use of practitioner research or action-research designs is particularly relevant in the field of psychiatry for a number of reasons. Firstly, psychiatry is an extremely contested field, with many different and often competing accounts regarding the nature of 'mental illness' circulating (Parker et al.1995). Some of these accounts are more dominant than others, with biologically based accounts occupying a particularly elevated position (Johnstone 2000). Because of the inter-relationship between knowledge and power, the voices of those who do not subscribe to these dominant accounts, (often service-users and their relatives) may be marginalized or silenced (Parker et al.1995). A more action-orientated research process may therefore allow for some of these 'other' marginalized voices to be heard by actively engaging with service-users and those that are close to them, as well as staff, and ensuring that these diverse perspectives are re-presented, both in service-planning meetings and also in the research text. Wilkinson & Kitzinger (1996) have, however, drawn attention to the complex power issues associated with attempts to 'represent' the views of others who occupy less privileged positions. There is a risk that the voices of those who are relatively powerless, (in this instance, the service-users) are distorted and appropriated in such a way that the interests of those with power (the professionals) continue to be served. In this study I have therefore attempted to re-present a multiplicity of perspectives rather than privileging a single 'authoritative' position.

A further key argument for action research relates to the pressing need to develop practice in the field of psychiatric hospital treatment. A national survey of acute in-patient units which was published shortly after the introduction of the reception meetings highlighted the poor standards of care that are often delivered in these settings and the over reliance on physical methods of treatment such as medication, at the expense of other approaches such as psychotherapy (Moore 1998). Calling for immediate action to improve standards within admissions units, the Sainsbury Centre for Mental Health (2002, p.1) has stated, *"The situation is little short of a crisis and has to be addressed now. In some instances, the*

quality of care is so poor as to amount to a basic denial of human rights". Research initiatives which are engaged with improving practice are therefore of particular relevance in helping to address the difficulties which pertain to these settings.

Thirdly, psychiatric services are traditionally orientated towards the needs of individuals in isolation from their families and wider social networks, and a number of studies have described the tensions which are often seen to exist between psychiatric staff and the relatives of service-users as a consequence of this (see, for instance, Winefield & Burnett 1996). In relation to practice development, other commentators (Haley 1980; Fadden 1997; Smith & Velleman 2002) have discussed the barriers to implementing more social or family-orientated approaches within mainstream psychiatric services, and have suggested that difficulties are encountered for multiple reasons associated with the organizational and professional culture of psychiatry. A contextually-sensitive and engaged research approach was therefore particularly relevant for the exploration of these practice dilemmas.

At a more personal level, I also felt an ethical imperative to engage in the research process in such a way that it might act as a catalyst to practice development. Admission to a psychiatric unit can be a fraught experience for the person concerned and for those close to him or her, and the people who participated in this study generously gave time to share their experiences with me, despite these circumstances. Similarly, staff in the research site were often struggling to maintain a service in the face of multiple conflicting demands and minimal staffing levels, themes which will be discussed later in the study, (see chapter 7). Miller and Glassner (1997) suggest that a principle concern of participants in qualitative research interviews which will influence the account they provide is what will become of the interview. This interest in how the material will be used extends beyond concerns about confidentiality, according to Miller and Glassner (1997, p.104), who state that *"interviewees want to know that what they have to say matters"*. Several participants in the research commented that they hoped that it would help to improve services.

Ideas from the fields of action research and, more particularly, practitioner research therefore have an important bearing on this study, and these research approaches will be discussed in more depth in chapter 4 of this thesis. The discussion will now turn towards an account of the key principles associated with a systemic approach to practice, since systemic

ideas and practices were used extensively within the reception meetings which are the focus of the research.

Systemic practice and the reception meetings

Gorell Barnes, Down and McCann (2000, p.13-14) suggest that a systemic approach can be differentiated from other models of intervention in the following ways:

- Systemic practice considers current context, in terms of what is happening in people's lives now, as well as the influence of the past. This focus upon context includes the ways in which our lives as individuals are connected with and constrained by dominant discourses from the wider socio-cultural field.
- It attends to the ways in which current and past relationships come to form conversational patterns in peoples minds, and therefore influence their perspectives and daily practices.
- The multiple ways in which these 'inner' and 'outer' conversations are patterned, the 'stories told' and 'stories untold' (Pearce & Pearce 1998), and the priority given to some accounts over others, are viewed by systemic practitioners as related to the ways in which misunderstandings, conflicts and problems can arise and become perpetuated over time.

Contemporary systemic practice is therefore concerned with the ways in which meaning is socially constructed in language, moment by moment, by interlocutors in conversation. Meaning is multiple rather than singular, and understanding is always partial, related to context and to where we are positioned as individuals in relation to one another (Anderson 1997). As such, a systemic approach stands in stark contrast with the more positivist, individually focused approaches which tend to predominate within psychiatry (Gergen, Hoffman & Anderson 1996).

This relational focus also leads to a concern with the ways in which transitions impact upon relationships (Burnham 1986), and how the perceptions of the people involved might alter in response to these changes. Since psychiatric hospitalization is a potentially important transition

which may lead to significant re-storying of family relationships (Whittle 1996), the staff who developed the reception meetings were eager to discover what opportunities might be afforded through the application of a systemically-orientated approach at this point of transition from home to hospital. The team hoped that systemic network meetings occurring at this key moment might allow the service-user, family members and staff to explore the multiple meanings ascribed to the transition, and to collaboratively generate ways of progressing the situation.

Because of the tensions between this relational approach and the more reductionist culture which tends to predominate within psychiatric hospitals, however, a number of issues and tensions were associated with the implementation of this new service development.

Using systemic approaches in hospital settings

Rivett and his colleagues suggest that the provision of family or network orientated approaches in psychiatric hospital settings is inherently complicated, since hospital admission may inadvertently reinforce an idea that the family have failed because their relative has needed to be removed (Rivett et al.1997). The associated feelings of failure and blame lead to a potential schism developing between the hospital staff and the family, resulting in poor communication and an increasing sense of mutual frustration (Whittle 1996). In addition, difficulties in implementing family or network approaches have also been attributed to the dominance of biological theories in these settings (Haley 1980). Perhaps for these reasons, there is relatively scant clinical or research literature discussing family or network orientated approaches in hospital environments, and Haley (1975) explicitly warned family therapists against attempting to undertake this work. Haley argues that the introduction of systemically orientated treatment approaches represents a challenge to the individually based ways of working which generally predominate and is therefore likely to be resisted by staff who are aligned to these traditional ways of working. For this reason, systemic approaches can not simply be 'grafted onto' traditionally orientated hospital units, since family work represents an implicit challenge to the organizational status quo. Haley's argument that family-orientated approaches are fundamentally incompatible with traditionally-orientated hospital environments is overly pessimistic, but it is likely that he was writing with his tongue in his cheek to provoke and challenge professionals into

finding ways of introducing family work into mental health settings. His warning that this is not a simple or straightforward affair is well made, however, and in this research one of the areas that was explored was the complex relationship between the reception meetings and the organizational culture of the research site.

At the same time, from a systemic point of view these difficulties make the introduction of family or network orientated approaches all the more crucial since engaging with the service-user's family or social network offers hospital staff opportunities to intervene in such a way as to minimize the potentially damaging effects of hospital admission. Admission to psychiatric hospital can be regarded as a potentially major life event which may profoundly impact on the relationships between the person who is admitted and their 'significant others' such as family and friends, shaping their perceptions of themselves and of one another in crucial and enduring ways through amplification of an illness narrative and reinforcement of a potentially stigmatising psychiatric labelling process (Scott & Starr 1981; Whittle 1996). Despite the shift towards community care in recent years, in-patient provision continues to be a crucial aspect of the 'spectrum of care' provided by psychiatric services in response to more severe problems. The Sainsbury Centre for Mental Health (2002) recently estimated that there are approximately 14,000 acute inpatient beds in England and 138,000 admissions per year.

The reception meeting team & the impetus for the meetings

The group of professionals who met together to develop the reception meetings was diverse, consisting of workers from hospital and community settings and one colleague from the nursing department of a local university. These staff were also from different professional disciplines, including nursing, medicine, social work and support workers. A smaller number within the group had experience and training in family therapy, and had worked together in a family therapy service within the organization for a number of years. These staff with a background in family therapy, which included myself, therefore had a history of working together and brought this shared experience, as well as expertise in working with families to the reception meeting team. Other colleagues became involved principally because they felt that services to families were lacking in the Unit. Two members of staff who became involved had direct experience as family carers of people who had experienced

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severe mental health problems, and therefore had valuable experience from "both sides of the fence". This staff group formed a 'reception meeting team' who took a lead responsibility for promoting the development of the meetings across the wider service. The composition of the reception meeting team and the strategies used by this group to promote the meetings within the wider service will be discussed in greater depth in Chapter 3.

At the time when the reception meetings were introduced, a range of difficulties were facing in-patient services nationally, which were associated with factors such as high bed occupancies; service-user populations who had diverse and complex difficulties; poor staffing levels; and a limited range of activities and therapies available in these settings (Johnstone 2002). At a local level these concerns created an impetus to improve standards, resulting in a potentially more fertile environment for the introduction of new ways of working.

In addition to these concerns that were being expressed at a broader, national level, there were several factors which influenced the reception meeting team in developing and introducing the meetings, including their own professional and personal experiences within psychiatry and the influence of clinical and research-based literature from the family therapy field. These factors are described in the sections that follow.

Practice-based influences

There was a desire on the part of the staff concerned to shift the service in a more 'family friendly' direction. For those staff who had worked together in the family therapy service, (including myself), this wish arose from an interest in systemic approaches to practice, while for those colleagues who had direct experience as family carers of people defined as mentally ill, the desire for change sprang in part from the frustrations they had experienced in their own lives about being excluded by services.

The staff who were involved in the reception meetings also experienced a degree of frustration with the dominance of the medical model within the Unit to the exclusion of other approaches. An over-emphasis on biological factors within psychiatry can result in approaches to practice developing which are non-systemic, non-reflective and not tailored to

the needs of specific service-users and their families (Pakman 1999). It was hoped by members of the reception meeting team that inviting the person's immediate social network to participate in the reception meeting would lead to an enhanced awareness of the importance of social context within the wider staff group, and to the subsequent development of more relevant treatment plans. This frustration with the dominance of a biological framework was not only experienced by practitioners from non-medical disciplines, since medical staff in the Unit were also eager to see a broadening of the range of services available. One of the reception team members was a consultant psychiatrist, for instance, and the Medical Director for the organization was also highly supportive of the project.

In addition, feedback from relatives and carers about the lack of information they received and about not being sufficiently involved in the treatment process also provided an impetus for the development of the reception meetings. This feedback came from several sources, including direct comments and occasional complaints from families, discussions with local user and carers' groups, and also from the reported views of families in the published literature (Winefield & Burnett 1996).

Influences from the clinical and research literature

Members of the reception meeting team were also influenced by the literature which examines the impact of psychiatric hospital admission on the service-user and those close to him or her, The writings of the psychiatrist and family therapist Dennis Scott (Scott 1973; Scott & Starr 1981) were particularly influential here. Scott offers the concept of 'closure' to describe a rift that can occur in the psychological and emotional bonds between the person who enters hospital and their significant others. According to Scott, closure occurs when the person in crisis comes to be seen as 'ill' and their difficulties are no longer seen as related to the social and interpersonal contexts in which they initially developed. At the point of admission the family may withdraw, with responsibility for 'the problem' (the person) being transferred to the professional network. The term 'closure' is not used by Scott to suggest a process of physical distancing, and neither is it used in the commonly understood sense of a process of emotional resolution. Rather, it describes a closing off or impoverishing of the more intimate and personal dimensions of the relationship that ensues as a consequence of

the labeling process and the development of illness based constructions of identity (Reed 1999). By creating opportunities for the service-user, family and professional system to engage reflectively in open dialogue about the problem, thus generating multiple accounts of the situation, the reception meeting team hoped that the new service would help to minimize the process of closure.

In addition, a small but important body of research exists which highlights the value of social network meetings in mental health settings. Network therapy was developed in the sixties by Speck and Attneave (1973). Rather than inviting members of the immediate family to therapeutic sessions, Speck and Attneave included members of the wider system such as extended family, friends, neighbours, colleagues, professionals, and so on. These network meetings could be very large, with upwards of seventy people gathered in the family's home at times (Speck 1998). Speck and Attneave argued that through this process of connection with a wider community, collective energy and resources could be tapped into, thus providing an impetus and context for change. The practice of convening large-scale meetings has not been widely adopted, however, possibly because of the demanding process of arranging and facilitating such meetings. Smaller-scale meetings, which might include members of the family and involved professional systems have been used more frequently in different health and social care settings, and Attneave (1990) argues that convening this smaller, 'core' group is frequently sufficient to mobilize change. The network approach that was examined in this study was based around working with these smaller family / professional groups rather than the large scale assemblies originally described by Speck and Attneave.

Although the volume of literature from the UK regarding network meetings in psychiatry is scant, these approaches are more prevalent across Scandinavia, particularly in Finland (Alanen 1997). The innovative literature from Scandinavia was a major influence on members of the reception meeting team, and significantly shaped the theoretical assumptions and working practices team members. The Finnish social network approach is therefore discussed in some depth in chapters 2 and 3.

Policy Influences

At the time that the reception meetings were first developed, government policy was also beginning to move services towards ways of working which included greater collaboration between different professionals and agencies and which were more inclusive of service-users and their families. The Care Programme Approach (C.P.A.) was introduced in 1991 with the aim of providing a framework for the community treatment of people defined as 'mentally ill'. Guidelines for the implementation of the C.P.A. stressed the importance of involving relatives and other carers in planning, monitoring and reviewing care (Dept. of Health 1996). Because the C.P.A. was principally designed to foster better co-ordinated community care, the importance of careful planning prior to a service-user being discharged from hospital was emphasized. C.P.A. meetings which were attended by the service-user, their relatives and members of the hospital and community-based professional network, and therefore routinely took place before discharge to discuss the treatment package that would be implemented when the person left hospital. No similar requirement was placed on services to arrange planning meetings at the point of admission to hospital, however, and so the introduction of reception meetings was perhaps viewed as filling a gap by some staff. This is not to say that the reception meetings were simply an alternative form of C.P.A. meeting that occurred following admission rather then pre-discharge, however, as there were significant differences in the manner in which these different meetings were conducted. Staff who facilitated the reception meetings aspired to generate a more exploratory or reflective ethos which was more focused on building relationships and less orientated towards specific goals or outcomes than was the case in C.P.A. meetings (Reed, Stevenson & Wilson 1998). What the two different types of meeting did share in common was an emphasis on bringing together the service-user, family and professional network. The prior introduction of the C.P.A. therefore potentially paved the way for the introduction of reception meetings within the Unit. Government initiatives and policy developments subsequent to the inception of the reception meetings such as the National Service Framework for mental health (Dept. of Health 1999a) have continued to underscore the importance of services working in partnership with families and other carers.

Research site and the reception meetings

The research site was an acute psychiatric admissions unit with 37 beds, attached to a district general hospital in the North-East of England, (the Unit will be very briefly described here, and is discussed in greater detail in chapter 3). The team of staff within the Unit comprised the usual range of professional disciplines associated with psychiatric in-patient services. Four multi-disciplinary community mental health teams (C.M.H.Ts) were linked to the Unit, and staff from the hospital and community teams developed a range of methods to decrease the gap that traditionally existed between these two areas of service. The reception meetings were, in part, one of the ways of attempting to bridge this gap.

When the hospital and community staff who formed the reception meeting team first conceived of the meetings it was anticipated that they would occur as early as possible following a person entering the Unit. This early phase of admission is a time of particularly high stress for families, and a time of flux when all concerned (service-user, family, professionals) are attempting to make sense of the situation (Scharfstein and Libbey 1982). It was also envisaged that the meetings would be attended by the service-user and those 'significant others' who were closely involved with the person and the problems which led to hospitalization. This might include, for instance, relatives or close friends; any professionals from outside of the hospital team who are involved in the person's care; and members of the in-patient team. The meetings were hosted by members of the reception meeting team.

The name 'reception meetings' was chosen in the hope of conveying friendliness to the family. For similar reasons, the team spoke of themselves as 'hosting' the meetings rather than using more professional or formal terms such as 'facilitating' the discussion (Reed, Stevenson & Wilson 1998). In line with postmodern developments within the systemic field (Hoffman 2002), particular attention was given by members of the reception meeting team to language within the meetings, with staff attempting to eschew professional jargon in favour of the language and metaphors used by the family members and other people present. The style of the meetings was also guided by a belief that everyone present had a contribution to make and that the professionals were not expert on other people's experience (Reed, Stevenson & Wilson 1998). Staff hosting the meetings therefore attempted to

encourage different points of view to be expressed, believing that the expression of multiple perspectives enhances dialogue and fosters enriched understandings of the situation.

Preliminary aims for the research

The aims of this research have been modified and extended as the research process unfolded and as my thinking about the topic developed. My initial formulation of the research aims was couched in terms such as 'evaluating the effectiveness' of the reception meetings, language that increasingly seemed incongruent with the qualitative orientation of the study, and the nature of the reception meetings. The research has been exploratory in nature, entailing processes of engaging with different voices and to construct new and richer meanings about the reception meetings, rather than a linear process of measuring or quantifying 'effectiveness'. I therefore later reformulated the preliminary research aims in a form of words which was more consistent with the qualitative nature of the research:

1. To explore the perceived meaning and significance of the reception meetings for participants through the narratives told about them.

2. To develop an account of the interplay between different forms of communication that occurred in the reception meetings. In particular, the research aimed to consider whether participants in the reception meetings experienced the communication that occurred as participatory and dialogical in nature or rigidly monological and impositional.

3. To consider the relationship between the reception meetings and the organizational context of a psychiatric admissions Unit.

4. To consider the implications for future practice

In formulating the preliminary research aims in this way, I was essentially concerned with matters of voice. My intent was to explore questions relating to these concerns such as: What stories did participants tell about their experience of voice in the reception meetings?

Did they feel able to speak and be heard? What, if any, stories did participants tell about how participation in the reception meetings influenced their subsequent patterns of relationship with the others who were present at the meeting? How did the kind of talk that it was possible for participants to engage in within the reception meetings relate to their social position (i.e. service-user, family member, professional) within the organizational culture of the Unit? This concern with voice in the study resonates with postmodern developments in the systemic therapy field (Hoffman 1993) as well as in qualitative research (Brown & Gilligan 1992).

A major purpose in exploring these concerns has been to generate what Pearce (1992) describes as 'practical theory', that is, a form of theory that is useful to both myself and to others working in similar practice situations. It has therefore been my aspiration to construct a story through the research process which can potentially inform and inspire others in this field, and which might therefore contribute towards the development of more inclusive, systemic approaches within psychiatric in-patient services.

Chapter 2. Literature review

In the previous chapter the rationale for the development of a systemically-orientated service such as the reception meetings within a psychiatric in-patient service was briefly considered, and some difficulties associated with implementing family-based approaches in a hospital environment were identified. A number of authors have discussed the distant and sometimes difficult relationships between families and staff that are described as characteristic of the adult mental health field, and this literature will be reviewed in the first part of this chapter to develop a more detailed understanding of the contextual barriers to collaborative family-staff practice in these settings. The discussion will consider a range of themes that have been identified within the literature, including the institutional history and reductionist treatment culture of psychiatric care; the influence of professional training; and the contribution of dominant assumptions within Western culture regarding hospital and illness.

Having examined these contextual barriers, I will consider a body of literature which discusses the development of different models of family and social network-orientated practice in hospital settings. In this latter discussion particular attention will be given to the literature regarding projects that bear similarities with the reception meetings. In particular, the Finnish social network approach, or 'open dialogue' approach (Seikkula, Alakare & Aaltonen 2001) will be examined in some depth, as this model was particularly influential in relation to the development of the reception meetings (Reed 1999).

Relationships between service-users, families and staff in hospital settings

A number of studies have highlighted problems regarding communication between psychiatric staff and the families of people who are defined as mentally ill. Winefield and Burnett (1996) used questionnaires to survey the views of family members with a relative diagnosed as schizophrenic, and reported that several family members who participated in the study felt that the professionals they had contact with were poor at sharing relevant information with them. This theme is repeated in a survey of the views of mental health service-users and their relatives undertaken by Leavey et al (1997), which enquired about

levels of satisfaction with services one year after discharge from hospital. Again, relatives expressed particular concern about the lack of information provided by professionals. Those service-users who had been compulsorily detained in hospital under the Mental Health Act (1983) expressed greatest dissatisfaction with services, as did their relatives. One of the conclusions drawn by the authors is that every effort should be made by psychiatric professionals to include and support relatives from the very beginning of the service-user's treatment, to improve communication between all concerned.

In a study undertaken for the influential Sainsbury Centre for Mental Health, Shepherd, Murray and Muijen (1994) report similar concerns from families regarding lack of information received from staff in a study they undertook using a combination of qualitative and quantitative methods to examine the perspectives of service-users, family members and professionals regarding services for people diagnosed as schizophrenic. A further theme arising from this study was the relatives' perception that the professionals were not interested in their point of view, although the family members were frequently the primary care-givers. The tendency of professionals to focus exclusively on the service-user to the exclusion of the family was identified by relatives as a major source of frustration and discontent with services.

Focusing more specifically upon relationships within in-patient settings, Rose (1985) undertook a qualitative study which explored the experiences of families with a hospitalised relative. Drawing from data generated in semi-structured interviews, Rose suggests that family members had a strong wish to become active participants in their relatives care and to identify their own role within the hospital treatment setting. Since psychiatric hospitalization may represent a period of crisis and destabilisation for families, Rose suggests that family members will therefore be actively attempting to make sense of the events and people encountered through the hospital experience, in order to understand and become a part of the treatment process. Rose offers the concept of 'assimilation' to describe the process of constructing meaning that families engage in within the new context of the hospital. According to Rose (1985), this assimilating process entails several activities on the part of families, including attempting to understand and adjust to changes in their relationship with the relative who had been defined as ill; becoming orientated to the hospital environment, including the roles of the various staff and the hospital routines and

philosophies; and also trying to evaluate the reasons and methods concerning psychiatric treatments as applied to their relative.

Rose reports that the assimilating process was often problematic for the families who participated in her study. These families described feelings of discomfort and isolation from the hospital, with some relatives expressing the view that the staff were only interested in the patient, to the exclusion of themselves. Family members also described feeling puzzled about the roles of staff, and Rose suggests that their preconceived notions regarding the functions of health professionals tended to be formed through experiences in more 'medical' settings; staff were viewed as experts who would be able to answer any questions about their relatives 'illness', its treatment and prognosis. Rose describes the families as feeling disappointed when these preconceived ideas did not apply in the psychiatric setting and they were not provided with concrete and definitive information by staff in response to their questions. Rose also notes that families who were not provided with clear information regarding the roles of staff expressed stronger feelings of isolation from the hospital.

Anderson (cited in Rose 1985) also undertook a qualitative study examining relationships between psychiatric staff and families of hospitalized service-users, and reports that families frequently felt isolated from the hospital, and experienced few opportunities to talk about their feelings or access support. Anderson also suggests that this situation did not usually improve over the time that the person remained in hospital, with families continuing to feel anxious, concerned about the future and unsupported by staff. Consequently, family members may appear to staff as resistant to therapy because of their fears and concerns about the situation. A similar point is raised by Hatfield (1983) who argues that there is a tendency for staff to label families as dysfunctional when the family does not fit with their professional models.

Based upon his experience in developing a family-orientated psychiatric hospital, Harbin (1982) contends that the non-inclusion of families in in-patient settings is a situation which has persisted not only because of reluctance on the part of staff to engage with relatives, but also because of the wishes of the families themselves to remain distant. Harbin argues that since most people are brought into psychiatric hospital because their family or the local community are unable to tolerate their disturbing behaviour, families may wish to withdraw

from the person and leave them in the hands of the hospital. This view is countered by Anderson and Reiss (1982), however, who challenge the notion that families seek to rid themselves of the burden of the patient, arguing that many families strive to maintain the person in their home if at all possible, even in the face of extreme difficulties.

To underline the main points raised so far, a difficult and distant relationship between staff and family members within psychiatric settings has been highlighted in several previous studies (Rose 1985; Shepherd, Murray & Muijen 1994; Winefield & Burnett 1996). Families who participated in these studies frequently described feeling excluded from the treatment process, and expressed the view that their knowledge and expertise as primary care givers was not recognized by staff who appeared exclusively focused on the needs of the individual service-user. Family members, whose initial expectations of the hospital may have been shaped by experiences in physical health care settings also expressed puzzlement regarding the hospital culture and the roles of staff, as well as the lack of concrete information about the 'illness' (Rose 1985). Since it was into an organizational and relational context of this sort that the reception meetings which are the focus of this research were introduced, it is important to examine the various factors which have been identified within the previous literature as constitutive of this distant relationship between family members and staff.

The legacy of the institution and organizational constraints

A number of the difficulties identified in the previous research in the relationships between psychiatric professionals and families can be related to the institutional context of mental health services. There is a vast previous literature regarding the institutional treatment of people defined as 'mentally ill'. The groundbreaking work of the sociologist Erving Goffman in the sixties (Goffman 1968), for instance, stimulated widespread critical discussion regarding the role of institutions within society (Stanley and Reed 1999). Because of the volume of literature in this field, I have restricted the discussion that follows to an examination of writings which address those factors which impact upon relationships between families and staff in psychiatric contexts, in order to maintain a focus on the key concerns of the research.

Harbin (1982) discusses the role of the institution within psychiatry, tracing the historical development of psychiatric hospitals from the early sequestering of the "mentally ill" in prisons and alms houses, and towards the advent of more humane, 'moral' treatment of hospitalised people in the 19th Century. He argues that these attempts to introduce more humane treatments were undermined by inadequate facilities and by the large numbers of patients contained within them, leading to the custodial warehousing of people with a variety of psychiatric and neurological problems. One of the consequences of this long-term institutional provision was the increased separation of the hospitalized patient from his or her family, with consequent difficulties for the person and their relatives in attempting to reintegrate after discharge. While the development of pharmacological and other treatments along with the shift towards treating greater numbers of people in the community has led to a reduction in the populations within in-patient facilities and more brief patterns of admission, Harbin argues that the basic assumption underlying hospital treatment remains unchanged: an individually orientated model of mental illness. The legacy of institutional care, Harbin contends, has led to a state of affairs where families are routinely and persistently excluded from the hospital treatment process. Harbin is one of the few authors from the family therapy field who has focused on the applications of family systems ideas within psychiatric hospital settings and although his work in this field was published some time ago (Harbin 1979; 1982), his analysis of the institutional and organizational barriers to family involvement remains pertinent, with several of the themes he developed being echoed in the more recent literature that will be discussed later in this chapter.

The French historian and philosopher Michel Foucault is more sceptical than Harbin regarding the intentions and social processes associated with these historical shifts in the treatment of those who are designated as 'mentally ill' (Parker et al. 1995). Whereas Harbin regards the development of institutional hospital 'treatment' as being broadly motivated by a desire to provide a more humane response to suffering, Foucault is critical regarding the medicalization of experience (Luepnitz 1992). For Foucault, disciplines such as psychiatry, psychology and psychotherapy as primarily instruments for the surveillance, regulation and control of individuals. He was therefore concerned with the workings of power implicit in the process whereby some people in a society are classified as 'normal' and others as 'abnormal', and with the role of institutions such as hospitals in the maintenance of these divisions and classificatory practices. Because of its social function as a site of

classificatory and regulatory practices, entering hospital necessarily entails a process of separation of the individual from their ordinary relational and social contexts.

Mansell and Malik (2000) have summarized the various institutional and organizational factors which they believe act as obstacles to closer contact between psychiatric hospital staff and families. These factors include an over-emphasis on physical methods of treatment; the resource constraints facing services leading to low staffing levels and restricted training opportunities; the presence of staff who are opposed to change; and also a lack of integrated service systems which might facilitate communication between hospital and community. Mansell and Malik conclude that the patterns and routines within psychiatric wards are often shaped by the 'needs of the hospital system' rather than those of the people using the service, and other systems such as the service-user's family tend to be regarded as peripheral or a threat to the smooth running of the organization.

Wright (1997) has also highlighted the significance of organizational factors such as staff shift patterns within the hospital on determining the degree of contact between staff and families. Arguing that the role of negative attitudes from staff towards families has been over-emphasized in the previous literature, Wright counters this by proposing that if staff work patterns are developed which increase their availability at evenings and weekends when families are available to attend, then increased contact is facilitated.

The view that family-orientated practices present a challenge to the culture and organization of psychiatric hospitals has also been expressed by Treacher (1984). Discussing the role of nursing staff in in-patient settings, Treacher contends that nurses tend to be strongly invested in maintaining a 'self-image' which is orientated around caring and the development of an intimate, supportive relationship with the patient. Working with the family may reduce the intensity of this one-to-one relationship and therefore distance the nurse from the patient. Faced with this tension, nursing staff are likely to resist abandoning their traditional role, according to Treacher. Since nurses are the largest professional group in hospitals, he concludes that attempts to introduce family work are likely to be unsuccessful unless the views of nursing staff and implications for their role are considered.

The relationship between professional training and psychiatric culture

While the perpetuation of distant relationship patterns between hospital staff and families within psychiatry may be understood as a consequence of the continuing legacy of institutionalisation and the organizational features of the hospital as a social system, a number of commentators have also argued that there is a recursive relationship between the kind of training that mental health professionals receive and the reductionist culture which predominates within psychiatry (Birch 1991; Fadden 1997; Haley 1975).

Birch (1991) has drawn attention to the manner in which the professional training and preparation that psychiatrists receive serves to maintain the dominance of individually-orientated perspectives on mental illness. Birch examined the instruction that psychiatrists receive regarding schizophrenia by undertaking a thematic review of articles on this disorder from two leading British psychiatric journals published between 1985-1986, (the British Journal of Psychiatry and Psychological Medicine). He found that the articles contained an almost exclusive focus on issues of pharmacology or discrete pathology from a medical perspective. Birch (1991) concludes that psychiatrists reading these academic journals are implicitly instructed that schizophrenia is a specifically biological affair for which research will eventually yield a medical cure. Social context comes to be regarded as, at best, of secondary importance.

Since Birch (1991) specifically examined the training and preparation received by psychiatrists, the exclusive emphasis on medical factors is unsurprising. That this medicalized focus is also characteristic of the views of psychiatric nurses, however, is highlighted by research undertaken by the Sainsbury Centre for Mental Health (Warner, Ford & Holmshaw 1997). In this study a number of mental health nurses working in different NHS Trusts in England were asked to identify the specific skills that they felt were needed by nurses in their work with people with severe psychiatric problems. All of the participants identified dealing with medication as a key area of nursing practice, but few referred to the relevance of psychotherapeutic interventions, and none mentioned family or network based approaches.

Harbin (1982) also contends that the individually-orientated training that most psychiatric staff receive contributes to a reluctance towards working with families. He argues that staff may not only feel that family work is counter to their training, but may also regard it as disruptive to the individually-orientated ways of working that they have become familiar with. Harbin goes on to argue that inter-team disputes regarding theoretical models or professional status may exacerbate the difficulty in introducing family-based approaches into an agency. Psychiatric staff often have conflicting theoretical and ideological positions, and if family work is seen as a challenge by those staff who favour more individually-orientated approaches, then it will be difficult to implement routinely. In addition, Harbin (1982) warns that those staff from professional disciplines such as social work, who generally receive more training in social models, might also be resistant to the service becoming more family or socially orientated if they have themselves become adjusted to the more individually-focused ways of working, or they may feel threatened when staff from other disciplines gain confidence in working with families, an area which was previously their professional province. A similar argument has been put forward by Haley (1975), who suggests that the forms of practice which prevail in mental health agencies are based on the preferences and interests of the professionals rather than upon the efficacy of these approaches. Since the majority of staff have been trained to work with individuals rather than families or wider networks, Haley contends that their professional status and sense of expertize may be challenged if family work is introduced.

Fadden (1997), a leading figure in the field of family interventions in schizophrenia, evaluated the impact of a multi-disciplinary post-qualifying training in behavioural family therapy on the subsequent working practices of staff. The training specifically aimed to provide staff working in adult psychiatry with family intervention skills in relation to service-users who have been defined as severely mentally ill. 86 graduates of the training programme were surveyed to find out whether they continued to work with families after completing the course. Fadden describes the results of this study as a "major cause for concern", since the mean number of families seen by graduates was 1.7, and 40% of the families were seen by only 8% of the practitioners who were surveyed. The community-based staff who took part in Fadden's survey were more successful in engaging with families after training compared with those working in hospitals, suggesting that obstacles to introducing family-based approaches are felt across psychiatry but are particularly

entrenched in in-patient settings. Fadden (1997) draws a number of conclusions which are relevant to the present study regarding reception meetings. Like Harbin (1982) and Wright (1997) she identifies organizational factors such as staffing levels, workload demands and shift patterns as crucial. Fadden also warns that the presence of a small number of enthusiastic and committed staff is insufficient to sustain a family service in a traditional psychiatric setting, unless these wider organizational factors are also addressed. She goes on to argue that staff need to be trained both to recognise the importance of family work and also in convening and engagement skills with families, and questions whether these areas were sufficiently addressed in the training programme she studied, in view of the small numbers of families seen by graduates.

In recent years there have been calls from influential sources for a shift towards the inclusion of family-orientated practice within training programmes. The need for change in this area has been highlighted, for instance, in a report produced by the Sainsbury Centre for Mental Health which discusses the roles and training needs of staff (Duggan 1997). This report reviewed the training and development of professionals working with people defined as severely mentally ill, and recommends that all staff working in this field receive training in a range of specified core competencies, as well as in discipline specific skills. The ability to work collaboratively with carers and social networks is identified as a core competency for all staff. The report also recommends that service users and relatives of people identified as mentally ill should be involved in curriculum development, training delivery and the setting of service standards. Since this report was written for a wide audience including the Department of Health, NHS staff and managers, Universities, Purchasing Consortia, Regional Educational and Development Groups, and Social Services, it is potentially an important intervention in shifting the culture of services in a more 'family friendly' direction. At the time that the data was collected for this research, however, the training programmes for most psychiatric healthcare staff continued to be individualistic in focus.

In summary, the type of training that psychiatric staff have traditionally received has been highlighted by a number of commentators as creating an obstacle to the formation of collaborative relationships with the families of service-users. Training which is predominantly orientated towards working with individuals may deter staff from working

with families because they feel that they lack the skills required for this kind of work. Convening and engaging with families and wider networks, for instance, can be experienced as a daunting activity for staff who have not been prepared for this through their previous training. Under these circumstances, family work might provide a challenge to the staff's sense of their own expertize (Haley 1975; Harbin 1982). In addition, staff who are primarily schooled in individually-orientated models and methods may see family work as a marginal or even counter-productive activity.

Dominant socio-cultural discourses regarding hospitals and illness

A third factor which has been identified within the literature as contributing to the maintenance of a distant pattern of relationship between psychiatric staff and families pertains to the dominant cultural beliefs and stereotypes regarding the nature of psychiatric disorder and the role of the hospital (Scott 1973).

The potentially adverse impact of admission on the relationship between the person entering hospital and their significant others has been discussed from a family systems perspective by the psychiatrist and family therapist R.D. Scott and his co-workers (Scott 1973; Scott & Starr 1981). In a period of emotional crisis the beliefs of family members may be in a state of flux as they attempt to make sense of what is going on. When the behaviour of the person who is the focus of concern is inexplicable and alarming to the other family members, Scott argues that they are likely to draw upon dominant cultural beliefs about mental illness as an explanatory framework. The arrival of psychiatric professionals into a crisis situation may reinforce this view by signalling confirmation that the person is 'ill', particularly if the outcome of the professional intervention is admission to psychiatric hospital. In this situation any interpersonal difficulties associated with the initial crisis are likely to become obscured, as the attribution of illness locates the difficulties 'inside' of the hospitalised person, rather than in wider relational or socio-cultural contexts. Scott uses the term 'closure' to describe this process in which a person in crisis can become disconnected from the network of intimate family and social relationships in which they ordinarily live their lives, and which provides the context for the difficulties which have occurred (Scott & Ashworth 1967).

Support for the concept of closure is provided by research undertaken by Whittle (1996), who examined the impact of entering hospital on the causal and treatment beliefs of the people who were admitted, their families and the staff. These different groups were asked to complete questionnaires at the point of admission, indicating what they regarded to be the causes of the problem and a further questionnaire inviting them to state what they viewed as the most appropriate line of treatment. The same questionnaires were repeated one month after admission, and again two months afterwards. The results from this study suggest that following admission the service-users and relatives became more attached to biological theories of causation, while psychosocial causal beliefs decrease significantly. Whittle also contends that there is a link between causal beliefs and treatment beliefs, in that participants who held biological causal beliefs were more likely to regard medication as the most important treatment for their difficulties. The perceived relevance of psychotherapeutic approaches generally, and family orientated approaches in particular, seemed to diminish for these service-users and their families.

Whittle (1996) goes on to suggest that no similar shift occurred in the beliefs of the staff, who in his study were less strongly orientated towards biological theories to the exclusion of other factors[1]. Because of the lack of congruity between the beliefs of staff, service-users and families, Whittle conjectures that this was a state of affairs which was maintained by poor systems of communication within the hospital between these different parties. He suggests that the shift towards illness beliefs that occurred for service-users and their families was linked with wider cultural assumptions about why people need to go into hospital, rather than occurring as a consequence of ideas presented to families by the staff. Whittle also argues that drawing upon these commonly held cultural narratives to make sense of or assimilate the experience of hospitalisation can have a profound impact on future relationships between the service-user and his or her family, and on the life course of the problem which led to admission in the first place. Putting their faith exclusively in medication as a 'cure' may lead to the service-users and families becoming increasingly disempowered, as they lose sight of

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[1] It is interesting to note that other authors have suggested a mismatch of views between psychiatric professionals and service-users in the opposite direction to that described by Whittle, with professionals more orientated towards biomedical perspectives and service-users preferring psychosocial explanations (Johnstone 1999). While the influence of medical narratives is strong throughout the field of psychiatry in the UK, the degree to which particular teams are affiliated to this model will, of course, vary.

other strategies they may be able to adopt to resolve the difficulties which initially led to hospitalization.

The importance of professional avoidance of introducing a single, rigid explanatory narrative regarding a problem situation at a point of crisis has also been highlighted by Dallos, Neale and Strouthos (1997). These authors suggest that in the midst of a crisis family members may be hungry for information from professionals, and that if they are invited to subscribe exclusively to a single explanatory account, then their capacity to imagine alternative possibilities, and therefore different pathways for action, will be curtailed. Dallos and his colleagues therefore recommend that professionals should remain open and curious regarding different narrative accounts, and seek to explore these with families in a supportive manner to prevent amplifying pathological processes.

The concepts of 'closure' developed by Scott and his colleagues, and the research undertaken by Whittle which builds upon these ideas has particular significance for the present study, as this literature was one of the sources of inspiration which led to the implementation of reception meetings in the research site (Reed 1999). Despite the difficulties involved, the work of Scott and Whittle highlights the value of maintaining dialogue between the service-user, his or her significant others and psychiatric staff in order to prevent interpersonal closure from occurring. Fortunately, there exists a small but important body of literature regarding the development of forms of practice aimed at enhancing collaboration within psychiatric hospitals.

Literature regarding family-orientated practice within psychiatric hospitals

One of the themes highlighted within much of the literature is the crucial significance for families of their initial contacts with mental health professionals (Scott 1973; Whittle 1996). These early interactions between the two groups are not only influential in shaping family members beliefs about the nature of the problem, but also set a relational context against which future family and staff interactions develop. This theme is examined in much of the literature that will now be discussed, and some implications for practice are considered.

Benefits of connecting with families from the outset

Several authors have indicated that if staff do not take steps to include families from the outset, then invitations to participate which are extended at a later stage may be greeted with suspicion or scepticism. For instance, in a review of a 'psycho-educational' programme for the families of people with a diagnosis of schizophrenia, Reid, Lang & O'Neill (1993) found that 76% of relatives invited to attend declined, saying they felt too stressed or too busy to do so. These authors conclude that this unwillingness to participate was linked with the late timing of the invitation. Similarly, in relation to hospital settings, Scharfstein and Libbey (1982) argue that early contact between staff and families is crucial in preventing subsequent patterns of distancing and avoidance. Drawing upon their experience of arranging information sharing groups for families on a psychiatric hospital ward, these authors suggest that during the first few days of admission high levels of anxiety and uncertainty may be experienced by all concerned: the person who is admitted, their relatives and also the hospital staff, and that this anxiety may result in patterns of emotional distancing if not addressed. Scharfstein and Libbey therefore recommend that staff meet with the families within a few days of admission to attend to these anxieties. They note that the families who attended these meetings seemed to become more open in their interactions towards the hospital, while the staff, in turn, formed more positive views of the family.

Working within a psychiatric service for adolescents, the family therapists Peter Bruggen and Charles O'Brian have stressed the value of meeting with the family at an even earlier point, when a decision is being made about whether the young person should be admitted to hospital (Bruggen & O'Brian 1987). These authors suggest that a meeting occurring at this early stage provides an opportunity for expectations to be clarified and for issues of responsibility to be addressed, so that the young person and his or her family retain responsibility rather than this being 'handed across' to the professionals when the person enters hospital. The approach described by Bruggen and O'Brian may therefore be seen as aiming to counter the process of interpersonal distancing or 'closure' which can ensue when psychiatric hospitalisation occurs (Scott & Starr 1981).

Cooklin (1974) discusses the complex nature of hospital admission, in its meanings for the service-user, their family or significant others, and the referring agent, as well as for the

receiving ward culture. He argues that tensions between these different actors frequently emerge when the goals of admission are unclear. Cooklin describes how these difficulties can be reduced or prevented by arranging meetings at the point of admission between the service-user, hospital staff, and where possible the service-users family with the aim of exploring the reason for admission and developing a treatment contract with specified goals for the period of hospitalization.

The importance of involving families in the treatment process from the outset is also emphasized by Seikkula and his colleagues, (Seikkula et al. 1995). These authors discuss the transition within their service in the western Lapland area of Finland from traditional individually orientated methods of working to more inclusive approaches which routinely included the families and wider systems of the person in crisis. Seikkula and his colleagues suggest that families may respond with suspicion or reluctance when invited to meet with professionals if they feel that this is a departure from routine practice and that they are being singled out in some way. In this situation, the family may easily infer that the staff view them as the cause of the problem. When families are invited to participate in the treatment process from the outset on a routine basis, however, Seikkula and his colleagues suggest that this blaming message is removed and relatives respond positively. These authors propose that it is essential that staff regard families as partners in the treatment process, rather than as the target of treatment. In the innovative approach described by Seikkula and his co-workers, a social network meeting is convened as rapidly as possible when a person in psychiatric crisis is referred to their service, with the aim of collaboratively exploring the problem and developing a treatment plan. This approach will now be discussed in some detail, as it strongly influenced the style of working adopted by staff involved in the reception meetings project which were explored in the present study (Reed, Stevenson & Wilson 1998).

The Finnish social network approach

In the Finnish approach network meetings have been utilized as a key element of "needs adapted" psychotherapeutic treatment programmes which are tailored to the specific requirements of the individuals and families seeking help (Alanen 1997; Rakkolainen, Lehtinen & Alanen 1991). The term "network meetings" is used in preference to "family

meetings" as it is a less restrictive term, since meetings may frequently include a wider group of people than the immediate family. Potential participants might include, for instance, not only the service-user and his immediate family or significant others, but also extended family members, friends, neighbours, colleagues, any professionals who are involved as well as representatives from the psychiatric team. Network meetings at the point of admission to hospital have been described as a particularly useful forum for staff and families to explore the nature of the crisis and work together to develop ways forward (Seikkula 1994), and also as a therapeutic arena in which people experiencing psychotic break-down can create new and more coherent narratives about their life-situations (Holma & Aaltonen 1995).

Seikkula and Sutela (1990) draw upon systemic concepts concerning the way in which human systems co-evolve within an environment in their account of the relationship that develops between the hospital and family when a person is hospitalized. The family system and the hospital system join together to form a new, larger system which Seikkula and Sutela refer to as "the system of boundary". This family-hospital system of boundary is characterized by patterns of mutual and recursive influence between participants. Social network meetings which are arranged at the point of hospital admission provide an opportunity for members of this newly formed 'system of boundary' to meet together and share ideas and meanings. Rather than viewing the family as a focus for intervention, staff participating in the meeting focus their reflections on the co-evolving relationship between themselves and the family, since it is at this boundary that new meanings about the problem and possible ways forward are generated.

Outcome studies examining the effectiveness of the Finnish social network approach suggest that this way of working can lead to a reduction in the reliance on neuroleptic medication and hospital treatment as the primary treatment responses to people defined as severely mentally ill (Lehtinen et al. 2000; Pylkkanen 1997). While these studies present a compelling argument in terms of treatment outcomes for the routine use of network-based approach in psychiatric practice, they do not provide information about the experiences and preferences of those service-users, families and staff who were involved. Qualitative studies examining the Finnish approach or focusing on social network methods more generally are

scarce, underlining the importance of the present research where the views and experiences of people who participated directly in reception meetings are explored in depth.

One qualitative study examining the Finnish approach was undertaken by Seikkula (2002), who analysed transcripts of video recordings from network meetings to compare interactional processes within the sessions where there had been a successful or poor outcome. From an overall sample of 20 cases, (10 of which were evaluated as having achieved good outcomes, and 10 poor outcomes), Seikkula coded the transcripts in relation to dialogical and monological patterns of communication. He suggests that in 'good outcome' cases, the conversations in the network meetings were characterized by greater use of symbolic rather than 'factual' language and remained focused on specific themes for longer periods. In addition, the service-users and family members had both interactional and symbolic dominance, (in terms of speaking most often and introducing new phrases and ideas), in those meetings where the outcome had been positive. In these instances where the outcome was positive, the therapeutic team also appeared to respond to the families words in a reflective manner. Seikkula concludes that this study supports a central principle of a dialogical approach regarding the importance of responsive listening by staff to the language of the service-users.

In another qualitative study, Holma and Aaltonen (1995) utilized a narrative methodology to explore processes of interaction and meaning-making occurring in social network meetings in a Finnish psychiatric hospital. Like Seikkula, these authors performed a retrospective thematic analysis of video-recordings of network meetings. They concluded that the open conversational processes that occurred in the network meetings provided service-users who were in confused or 'psychotic' states with opportunities to construct new, more coherent narratives about their lives. Since the construction of meaningful life stories is essentially a social process (Gergen 1991), these authors contend that network meetings provided a forum where this process of narrative reconstruction can occur.

Vuokila-Oikkonen, Janhonen and Nikkonen (2002) also used a narrative research approach to examine patterns of communication between service-users, their significant others and professionals in network meetings which occurred in a Finnish psychiatric hospital. These authors reviewed video-recordings of the network meetings to analyse the extent to which

collaborative conversations about sensitive or painful issues occurred within the network meetings. They suggest that service-users frequently raised topics which were a source of distress for them, particularly concerning experiences of shame or embarrassment in relation to their status as psychiatric patients, which the professionals failed to respond to. Staff participating in the meetings tended to follow lines of questioning that related to their own professional concerns, rather than on those of the service-user and family. The authors conclude that further qualitative research is needed to generate new ideas about how staff might practice collaboratively in these social network meetings.

These Finnish studies which are discussed above are similar to the present research in that these authors employed a qualitative methodology to explore the network meetings. A key difference, however, is that the views of the participants in the meetings were not directly sought, whereas this is a central aspect of the present research into reception meetings. Since social constructionism is concerned with voice and perspective, the absence of previous studies which have sought the views of service-users and families is a striking omission.

In this section I have discussed the Finnish social network approach in some detail since this work was a major influence on the staff who developed the reception meetings which are examined in the present study (Reed, Stevenson & Wilson 1998). Concepts such as the importance of staff reflecting on the co-evolving relationship between themselves and the family, the importance of regarding the family as agents of change rather than objects of change, and of attending to language and story as the primary means of creating meaning are common to both approaches. The theoretical and practice-based dimensions of the reception meetings will be further discussed in the chapter that follows.

A major area of difference between the reception meetings and the Finnish approach is that the Finnish network meetings occurred in the context of a service culture which was orientated towards psychosocial methods of treatment (Alanen 1997), whereas the reception meetings were introduced into the more medicalized culture which is characteristic of UK psychiatry. One of the themes that is examined in this study is, therefore, how the reception meetings were perceived by the wider staff group working in the research site.

Summary and discussion

This chapter initially examined the literature pertaining to relationships between families and staff within psychiatric hospital settings, and explored factors which have been identified as constitutive of the distant relationships that frequently develop between these groups. Several explanatory themes in relation to the persistent nature of these obstacles to collaboration were identified, including the historical context of psychiatric hospital care and the persistence of reductionist modes of practice; staff training programmes which have tended to maintain a focus on the individual to the inclusion of the person's social context; and the wider socio-cultural assumptions within Western societies regarding hospitals and illness.

Having explored these contextual barriers to collaboration between psychiatric staff and families, the discussion then turned towards an examination of the literature regarding attempts to address this difficulty through the introduction of family and network-based approaches. A recurrent theme within this literature pertains to the value of arranging a meeting at an early stage in the admission process so that staff and families can negotiate meanings. The Finnish social network approach (Seikkula, Alakare & Aaltonen 2001) was discussed in some detail, as this dialogical model of practice provided something of a 'blueprint' for staff in the research site when developing the reception meetings.

There are important cultural differences between psychiatric services in Finland and the UK, however, in that the Finnish psychiatry tends to be more strongly orientated towards psychosocial treatment methods, while these have tended to be marginalized within mainstream services in the UK (Reed 1998). Family and network-based treatment approaches are used on a routine basis in the treatment of severe mental health difficulties within some areas of Finland, whereas the introduction of this way of working within the research site was an innovation that had no precedents locally. Similarly, there are few accounts within the literature of network approaches being used within in-patient settings in the UK, and none from the recent past. Attempts to transplant a way of working from one cultural setting to another in an unmodified form are unlikely to be successful, since from a systemic perspective, meaning is context-dependent (Bateson 1988).

The rationale for a qualitative study with a strong practice orientation within this important area of service development is therefore clear: follow up studies from Finland suggest that these network approaches provide an effective treatment modality for people experiencing severe psychiatric difficulties, but this work has been undertaken in a context where there is a stronger tradition of using 'talking treatments'. How similar kinds of meetings are perceived by those who participate in them within the more biologically-orientated culture of UK psychiatry is, however, a key question. In addition, the literature from Finland in this area within English language publications has a strong 'outcomes' orientation. There are very few qualitative studies, and those that have been published have not included interviews with service-users and family members in the design of the research. This seems rather incongruous, since the theoretical basis for the network meetings is social constructionist in orientation. Since social constructionism is explicitly concerned with issues of voice (Hoffman 1993), research which includes the multiple perspectives of those who take part in them is essential in generating an understanding of the value of social network meetings an as aspect of psychiatric service provision.

In the chapter that follows the research site will be discussed in more detail than was provided in the introductory chapter of the thesis, and the postmodern theoretical perspectives and working practices that were employed in the reception meetings will also be considered. Having orientated the reader towards the organizational context for the study and the specifics of the reception meetings, I will go on in the subsequent chapters to discuss the postmodern methodology that informed the study (chapter 4) and the research methods that I employed for the purposes of data collection (chapter 5) and interpretation of the data (chapter 6).

Chapter 3. The reception meetings and their organizational context

In this chapter the research site and the reception meetings that were the focus of the study will be discussed in greater depth than was appropriate in the introductory chapter of the thesis. This will allow the reader to develop a more detailed understanding of the general ethos and the working practices associated with reception meetings, as well as the organizational context in which they occurred. First of all a broad 'factual' description of the characteristics of the research site is provided. Following this, an account of the psychological and emotional ethos of the organization during the data-collection phase of the study is presented in order to provide greater contextual detail or a 'thicker description' (Geertz 1993) of the research setting. Acute psychiatric admissions units within the UK have faced a range of difficulties in recent years, and these issues will also be discussed in order to locate some of the key areas of difficulty that the research site faced within a wider context. The Unit was experiencing significant difficulties during the data-collection phase of the study, and an appreciation of the wider, national picture is crucial in countering any impression that these difficulties were unique to a particularly troubled or 'pathological' local service setting. Locating these organizational difficulties within a wider context also provides an indication of the broader relevance of the study.

Following this discussion regarding the research site, the reception meetings themselves will then be discussed in greater depth than has occurred previously. A guiding principle for the reception meetings was flexibility, so there was no set procedure that was followed in all instances. There was, however, a very loose format that staff hosting the meetings tended to follow, which allowed for variation according to the needs and preferences of those present. This general format for the meetings will be described, along with a discussion of some of the key theoretical and practice-based concepts which informed staff participation within the meetings.

In the discussion that follows it is important to locate my own position and the vantage point from which this account is written. In writing about the research site and the reception meetings I am inevitably positioned as a practitioner who actively participated in a range of activities within the research site and who was closely involved in the initial development of the reception meetings, as well as a researcher who was subsequently involved in

exploring the meetings through the research process. The practitioner dimension of my role therefore provided me with 'insider' knowledge in relation to issues such as the service culture; the rationale for the reception meetings as conceived of by the reception meeting team; the working practices that were utilized by staff in the meetings, and so on. This 'insider' knowledge is inevitably reflected in the account that follows.

The research site

The site for the research was an acute psychiatric admissions unit with 37 beds which offered a service to adult men and women, aged between 16 and 65 who were experiencing severe psychiatric problems. There was two parts to the Unit, a 26 bedded 'mixed' area, which accommodated both men and women, and an 11 bedded women only area.

The Unit as a whole was staffed by a clinical team of nurses, nursing support workers, medical staff and occupational therapists, as well as administrative staff. A range of other professionals also provided input into the treatment plans of service-users, including community psychiatric nurses and social workers, (at the time that the research was taking place there was a shortage of psychologists in the service, so there was very little psychology input). The Unit had developed strong relationships with local service-user and carer groups, who were also involved in a range of activities such as information sharing, advocacy and support groups, as well as in service-planning and review meetings.

Geographically, the Unit served a densely populated urban area in the North East of England, which experienced high levels of unemployment and economic deprivation. Racially, there was not a great deal of diversity in this area of the North East during the data-collection phase of the research. While black people and people from outside of the majority culture are disproportionately highly represented within psychiatric services in the UK (Fernando 1995), and are more likely to receive coercive treatment in hospital environments under Mental Health Act (1983) legislation (Browne 1995), the majority of the service-users, relatives and staff within the research site at the time that the data was collected were white. Therefore, although the service as a whole, like other psychiatric services in the UK, struggled to provide culturally sensitive services to people from ethnic minority communities (Fernando 1995), there was very minimal opportunity to explore this in this study.

In recent years there has been a number of concerns expressed regarding the services provided in adult psychiatric admissions units (Dept. of Health 1999b; MIND 2000; Sainsbury Centre for Mental Health 1998). These service areas have been described as troubled environments which are struggling to provide meaningful services to people with diverse needs, and which are frequently characterized by an emphasis on control and custody rather than therapeutic activities. A number of factors have been identified as contributing to these problems. The shift in policy from hospital to community based care has resulted in reduced numbers of beds and a situation where the populations within acute wards tend to be composed of those who are most disturbed. This problem is also further exacerbated by the increased use of street drugs in these settings (Johnstone 2002). Other factors which have been identified as contributing to the problems facing psychiatric wards include organizational factors such as poor staffing levels and limited access to further training for in-patient nursing staff, an over-reliance on the medical model which is inadequate in assisting with the complex psychological and social needs of service-users, and the increasing preoccupation within mental health services on the management of risk at the expense of therapeutic interventions (Moore 1998).

During the data-collection phase of the study the research site struggled with most of the issues identified above. Clinical interventions tended to be pharmacological rather than psycho-social, and there was also a lack of recreational or diversionary activities for service-users to occupy themselves. There was a consequent danger of service-users feeling bored and frustrated, particularly as several of those who enter psychiatric hospital do so under Mental Health Act (1983) legislation, and therefore may be unable to leave the immediate environment or may only be able to do so on a very restricted basis. A number of the service-users who participated in this study were detained in hospital and one of the dilemmas explored through the research therefore relates to the complexities associated with staff aspirations to engage dialogically with service-users in the reception meetings within an organizational context which carries a powerful social control remit.

Again characteristically for psychiatric admissions units during this period (Bowles 2002), staff were required to focus heavily on risk assessment and risk management activities. One of the central strategies employed in psychiatric hospitals within the UK for managing risk is the 'therapeutic observations' policy, whereby service-users who were regarded as posing a significant danger to themselves or to others are observed particularly attentitively by staff throughout the day to maintain safety (Dept. of Health

1999c). The 'observations' policy that was in place within the research site specified different levels of observations that might be carried out, according to the perceived level of risk. These ranged from a member of staff observing the service-user at agreed intervals (for instance, every 15 minutes), through to constant observation, where the nurse was literally required to ensure that the person was constantly in view. While this 'observations' policy was regarded within the organization as crucial in maintaining a safe environment, according to Bowles (2002) the demanding and time consuming nature of this activity within acute admissions units leads to a situation where staff have limited time or inclination to engage in other social or therapeutic activities with service-users. This issue is highlighted in the data collected for this study and will be explored in greater depth in chapter 7.

System for delivering nursing care in the research site

A rather complex system for organizing and delivering nursing care had been developed in the research site. This system was created in an attempt to ensure that care-plans for individual service-users were developed and implemented consistently despite service fluctuations created by factors such as staff shortages and complex shift systems. I will provide a brief outline of the arrangement that was in place, as this had consequences for the implementation of the reception meetings, both in terms of the availability of nursing staff to attend and also the extent to which they felt able to participate, as is highlighted in the data that will be presented later.

The system for delivering nursing care was as follows: on admission, each service-user was allocated a 'primary nurse' who was responsible for developing a care plan for the person, and ensuring that this plan was implemented and reviewed by the team. There were several factors that frequently resulted in the primary nurse being unavailable to meet with the service-user on a given day, however, including shift systems and the variety of other activities that qualified staff needed to attend to. Because the primary nurse was not available consistently the service-user was also allocated a 'named nurse' for the day who was responsible for implementing the agreed care plan. The named nurse might be a different person each day, and would often have had minimal previous contact with the service-user. In relation to attendance at forums such as the reception meetings or other meetings on the Unit, the situation might become further complicated, in that the designated 'named nurse' for a particular service-user might also be occupied with other activities at the time of the meeting, (for instance dealing with unexpected

crises that might have arisen). Under these circumstances, any member of staff who could be spared would go to the meeting, with their role being described as that of 'ward representative'. The ward representative might have only the sketchiest of briefings from other members of the team prior to attending the meeting.

Participating in a reception meeting as 'ward representative' under these circumstances might therefore be a difficult experience for staff to manage, and one which might leave them feeling very uncertain, as the data that will be presented later highlights, (see chapter 7).

The psychological and emotional ethos of the Unit

Because the study examined a new development in practice within a specific organizational setting, it is important to give an account of the general psychological and emotional mood within the research site at the time, which was frequently very tense. During the data-collection phase of the study a series of major incidents occurred which significantly impacted upon the culture of the agency. When the reception meetings were first implemented the Unit was temporarily sited in another hospital following a major fire. The confidence of many staff was shaken following the fire, and the physical environment of the temporary site was rather makeshift and poor. Shortly after this event two service-users also committed suicide within a few months of one another, and these tragic events inevitably further impacted upon staff morale and confidence, as well as that of some of the other service-users and their relatives who were in contact with the Unit. In line with the organizational policies that were in place, internal inquiries into these suicides were instigated, one of which resulted in a small group of staff being suspended from work for a time. Although this series of traumatic occurrences were not directly referred to by participants within the data gathered for the research, I had a prior knowledge of the events through my work as a practitioner within the organization, as well as an appreciation of the extent to which they had impacted upon some of the people involved in the Unit.

The introduction of the reception meetings therefore occurred at a time when the research site was rather destabilized by these crises. Organizational change may be very stressful for those involved under most circumstances, and a degree of 'resistance' to the process is therefore inevitable (Smith 1986). Receptivity to new ideas or new ways of practicing is likely to be further reduced when the people involved are under stress and

experiencing anxiety, and these recent traumatic events were bound to have influenced, at some level, the responses of staff to new developments such as the reception meetings.

The reception meeting team

The idea of the reception meetings initially arose out of conversations between members of a community-based systemic family therapy team operating within the local mental health services and a small number of staff from the Unit nursing team. In relation to my own position, I was a member of the family therapy team and my interest in exploring the application of systemic ideas in the hospital setting was encouraged by a change in my role as a senior nurse within the organization, which resulted in my holding responsibility for nursing standards within the in-patient service. A consultant psychiatrist who was involved in the community-based family therapy team also provided clinical input into the hospital, and was similarly eager to see greater collaboration with families occurring in this setting. As previously noted, these local developments were also a reflection of a national recognition that psychiatric hospital services had been neglected with the shift towards community care, and were in need of greater attention and resources to raise standards of practice (Dept. of Health 1999b).

A written proposal to implement this new service was developed and circulated to managers and lead clinical staff within the organization, and a 'reception meeting team' was subsequently formed which comprised interested staff from the hospital and community teams. The membership of the team fluctuated slightly across time, but staff from different professional backgrounds (nursing, social work, occupational therapy, medicine) were involved, as well as staff who were employed at different 'grades' within the organization, including nursing support workers who had no formal professional qualification. The inclusion of support workers in the team was potentially extremely valuable in embedding the reception meetings within the everyday life of the service, as it is this group of staff who frequently have the most direct contact with service-users and their relatives (Manshein 1989).

The 'qualification' for entry into the reception meeting team was therefore simply an interest in becoming involved in developing this new service. Some of the staff concerned had previously undertaken formal training in working with families while others had little training or experience but were eager to learn more. Two members of

the team also had experience of the psychiatric system from 'the other side of the fence', as parents of adult children who had received in-patient treatment. The team therefore comprised staff with a diverse range of valuable professional and personal life experiences and who shared an aspiration to improve the help and support provided to families within the service. No formal training programme in hosting network meetings was arranged for members of the team, but regular team meetings occurred to review this new service. In these meetings team members had opportunities to discuss to share their ideas and experiences, and ideas for refining and developing the service were generated.

A range of strategies were developed by the team to promote the reception meetings within the wider organization. Members of the team acted as 'service champions' for the meetings by discussing them in the different clinical and managerial forums they attended. In addition, written information about the reception meetings were distributed to community teams (see Appendix 2 for examples). A short series of training sessions about the reception meetings were also organized for staff in the wider service and delivered by members of the reception meeting team. The team therefore attempted to 'raise awareness' regarding the importance of working with families and social networks across the organization in the hope that the reception meetings might become embedded into the fabric of daily life within the Unit.

The reception meetings

Prior to presenting an account of the reception meetings, it is important to note that the team of staff involved in developing the meetings believed that each meeting should be different in the sense that there should not be a fixed procedure to be adhered to in all instances, as it was felt this would mitigate against the discussion being tailored to the unique concerns of the particular individuals who were present (Reed, Stevenson & Wilson 1998). Despite this caveat, it is possible to describe in broad brushstroke terms the overall ethos and guiding theoretical and practice principles which were characteristic of the way staff approached the meetings.

The ethos of the meetings

The general ethos and style of the reception meetings was shaped by two important factors. Firstly, the personal and professional histories and experiences of members of the reception meeting team inspired a conviction that engaging with family members following the potentially traumatic experience of psychiatric hospital admission is important and necessary work for staff to undertake. This desire to see the service adopt more 'family friendly' practices on a routine basis was driven for two members of the team by their own experiences with close relatives who had been hospitalised. Other team members who may not have experienced direct encounters with psychiatric services in their personal lives shared frustrations regarding the lack of opportunities to engage with families and carers within the service, and were keen to contribute to the development of a more 'open' or inclusive service.

The second important factor influencing the ethos of the meetings was the contribution of theoretical ideas and practices from the contemporary systemic practice field. Several members of the reception meeting team had previous training and experience in systemic family therapy, and were eager to apply ideas from this field within the Unit. A creative merging of these different areas of knowledge and experience, the 'insider' personal experiences of staff who has direct family experience of attempting to access services, coupled with professional knowledge regarding systemic therapy was therefore possible in the reception meetings. Any mode of psychiatric intervention, whether individually or systemically orientated, is potentially oppressive in its effects, and systemic family therapy has been accused by some of adopting a blaming stance by focusing on patterns of communication within families (Smith & Velleman 2002)[1]. The merging of these different personal and professional narratives and areas of experience within the reception meeting team was a potentially important resource in preventing theory becoming a hindrance rather than a driver for sensitive practice. In other words, the likelihood of the professionals concerned becoming 'blinded by texts' (Hoffman 1993) was reduced through the inclusion of these different voices and perspectives in the team.

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[1] The belief that systemic family therapy, particularly in its earlier years, pointed a finger of blame at families is simplistic, but has contributed to the marginalization of this approach within mainstream adult psychiatric services (Johnstone 1999).

Theoretical perspectives

The manner in which the reception meetings were conducted was strongly influenced by the postmodern approach of family therapist Jaakko Seikkula and his colleagues from the western Lapland area of Finland (Seikkula et al. 1995). As discussed in Chapter 2, Seikkula and his co-workers developed an innovative social-network based treatment programme for people experiencing severe psychiatric difficulties.

Theoretical influences which have shaped the approach developed by Seikkula and his colleagues include ideas about the constructionist nature of language and the dialogical basis of mind, as developed by the Russian literary theorist and philosopher Mikhail Bakhtin (Morris 1994). According to this perspective, our individual and social worlds are created in the flow of our 'outer' dialogues with others and our 'inner' dialogues with ourselves. It is through the process of dialogue, the process of speaking, hearing and being heard, that new accounts and connections are created. Staff who are facilitating the discussions within dialogically-orientated network meetings therefore aim to shift from a focus on problems or symptoms which is characteristic of mainstream medico-psychiatric practice towards a focus on language and speech. Similarly, the aspiration is to move away from monological conversations in which, *"there are those who question and those who reply"* (Andersen, cited in Hoffman 2002, p. 272), and towards a more collaborative form of inquiry in which uncertainty can be tolerated and in which multiple stories can be expressed and explored. This process of dialogue, according to Seikkula and his colleagues is empowering for participants in that it creates new understandings and an increased sense of personal agency (Seikkula, Alakare & Aaltonen 2001).

A postmodern focus upon language and dialogical patterns of communication has brought this metaphor of voice to the centre within contemporary systemic practice (Hoffman 2002; Penn 1999). According to Wertsch (1991), the concept of voice, or rather *voices*, is particularly helpful in highlighting the close relationship between individual 'internal' psychological processes and 'external' social communicative processes as well as the multiplicity of possible ways in which 'reality' can be represented and a problem can be approached. Wertsch (1991, p. 14) comments:

"The Bakhtinian focus on dialogicality presupposes more than one voice. In addition, the notion of "heterogeneity" in thinking contrasts with the assumption, often implicit and ethnocentric, that there is only one way, or that there is an obvious, best way to represent the events and objects in a situation. The notion of heterogeneity calls on us to consider why certain forms of speaking and thinking (voices) rather than others are invoked on particular occasions. ...we must consider how and why a particular voice occupies centre stage, that is, why it is "privileged" in a particular setting".

The metaphor of voice therefore brings into focus relationships of power between participants in a social encounter as well as patterns of dominance and marginalization in relation to the multiple narratives that are potentially in play. The authority invested in particular perspectives and accounts relates not to the objective 'Truth status' of what is said but rather to the social position of the speaker (for instance, whether they are speaker from a professional, service-user or family member position), and to the values and beliefs which prevail in a particular socio-cultural setting. Drawing upon these ideas, the purpose of the reception meetings as conceived of by the staff involved was to shift from polarized or monological accounts of the situation and to avoid the imposition of a single 'authorized' professional account of the situation by generating dialogue between all participants and creating a space in which polyphonic or 'multi-voiced' conversations could occur (Reed, Stevenson & Wilson 1998).

The introduction of the reception meetings with their postmodern, dialogically orientated ethos was a somewhat ambitious step within an organizational context which was orientated towards positivist conceptions of psychiatric treatment which focus upon the identification, diagnosis and removal of pathology, and in which the professional is the technical 'Expert' who can has superior insight into 'what is wrong' with the service-user. A central idea associated with the reception meetings was that shifting away from this more orderly modernist domain, albeit rather briefly for the space of a single meeting, might be sufficiently unsettling or enriching as to prevent a single narrative regarding the situation becoming elevated to the extent that other accounts could not be voiced or given serious attention (Reed 1999).

The aspiration of staff hosting the reception meetings was therefore to create opportunities for reflective conversations about important issues to occur between service-users, family members and professionals, so that different views could be shared and an open exchange of ideas could occur (Reed, Stevenson & Wilson 1998). It was believed that this process required that all who participated, whether professionals,

service-users or family members, should feel sufficiently comfortable within the reception meeting that they could discuss their ideas and thoughts in this group context. Staff hosting the meetings therefore aimed to create a sufficient sense of emotional safety so that participants could share their views openly in this way. This required creating a context in which a degree of uncertainty could be tolerated so that premature decision-making or overly instrumental modes of thinking are minimised. According to Mason (1993), a degree of uncertainty is a necessary condition for new learning and change to occur, since too great a degree of certainty can paralyse curiosity.

Format for the reception meetings

The following very loose format for the meetings was developed early on in the life of the reception meetings, and continued to be adopted by the reception meeting team because of its flexibility and adaptability. At the beginning of the meetings, the team members who were responsible for hosting or facilitating the conversation would usually explain to those present that there was no pre-constructed agenda for the discussion, and that the time could be used to discuss whatever people felt it was most important to talk about. It was also explained that the meeting might last for approximately an hour, but that it could end before that time if people wished it to. This was stated so that those present might experience some sense of control over proceedings, rather than feeling pressurized to continue if the meeting became particularly difficult or tense. Following this introduction, the team members hosting the meetings tended to follow this basic structure for the discussion:

- Everyone present was invited to introduce themselves, and to say if there was anything in particular they wished to discuss in the meeting. Opening conversations in this way is common practice within a family systems approach, as it facilitates multiple engagement and orientates the discussion towards the concerns of the individuals who are present (Andersen 1992).

- Discussions about any issues that were raised by participants would then occur. Members of the reception meeting team who were 'hosting' the discussion would aim to contribute to the conversation primarily by asking questions that might facilitate dialogue within the meeting. Again, asking questions from a position of 'curiosity' in order to generate multiple perspectives and new understandings regarding a situation is a hallmark of the systemic approach (Cecchin 1987). This is not to say that members of the reception meeting team would avoid sharing

knowledge, opinions or 'factual' information if asked to do so, but rather they would proceed cautiously in this respect in order to avoid imposing unsolicited advice or undermining the knowledge and expertise of the service-user and their significant others.

- A brief final discussion would usually occur which entailed clarifying any practical issues that needed to be carried forward from the meeting. Issues and queries regarding leave, medication, or making contact with other services were often raised at some point in the meetings, and it was important to clarify who would take responsibility for any decisions that were made or further enquiries that were necessary.

The reception meeting team believed that adhering to this very loose structure allowed for considerable freedom regarding the direction that the discussion might take. This relatively unstructured, co-evolutionary approach to the reception meetings was one of the major areas of difference by comparison with other clinical, planning or review meetings that occurred in the research site which were generally more task focused and less exploratory in style. The stories told by the service-users, family members and staff who participated in this research regarding their responses to this relatively unstructured type of meeting are therefore examined in some depth in the research.

Reflective processes

Attempts to create a context of 'safe uncertainty' (Mason 1993) in which genuine dialogue could occur between the different participants in reception meeting was, of course, an extremely complex phenomenon in a hospital context where the staff held great power. This included formal powers to hold people under the Mental Health Act (1983) and forcibly administer medication and other physical 'treatments' as well as the more informal authority or power of professional 'experts' (Andrews et al. 2000). In an attempt to enhance dialogical communication, staff hosting the reception meetings frequently made use of the ideas of the Norwegian family therapist Tom Andersen (1990) about reflective processes. There is no fixed format for the kind of reflective discussions that occur in the approach described by Andersen, but there is an emphasis on structuring meetings so that people can speak openly if they choose to, thinking aloud or giving voice to their ideas and associations in the presence of others. Professionals

working in this way will therefore tend to share their thoughts in the presence of the family, rather than engaging in 'behind the scenes' discussions and treatment planning.

When using this approach in the reception meetings, one of the team members would usually take a more active role in interviewing or talking with the others present, while the other reception meeting team member(s) tended to remain in a more quiet listening position. If a point arose in the meeting where it seemed to the team members concerned appropriate to do so, they would talk with one another about the ideas and impressions that had occurred to them during the course of the meeting. The others present would be invited to 'listen in' on this discussion, and then they in turn would be offered an opportunity to comment on what they had heard. The idea was that organizing conversations within the reception meetings in this way allowed participants opportunities to shift between 'outer' conversations with others and 'inner' conversations with themselves; that is, to talk and listen in a manner which allows for dialogue and new ways of thinking to emerge (Andersen 1992).

This type of reflective format was not used universally in the reception meetings, however. If staff felt that anxieties were running high, for instance, and that this approach might be experienced as over strange by participants, a more traditional format for the meeting might be followed. Andersen (1990) comments that if participants in a conversation are to be open and responsive to new ideas, then the style and content of the talk that occurs should not be over-unusual .

A further feature of the reception meetings that was influenced by the work of Andersen (1990) and Seikkula (1993) was that the staff who were involved tended not to meet together in advance of the meeting to engage in agenda-setting or diagnostic talk, or immediately afterwards to review what had taken place. The reception meeting team were concerned that if they did so, they might become over-attached to their own professional hypotheses or to a particular version of events rather than attending to what was said in the meeting, so that the range of ideas and possibilities that were generated would be reduced, and dialogue would not occur (Reed, Stevenson & Wilson 1998). While this unplanned or 'unscripted' approach to meetings has become increasingly common in the field of family therapy through the influence of postmodern ideas about therapy as a collaborative conversational process (Anderson 1997), it was more unusual

in a psychiatric hospital environment where meetings are usually more outcome-focused.

The timing and frequency of the meetings

The reception meetings were intended to occur soon after admission since this is often a time of great uncertainty and high stress for all concerned (Scharfstein and Libbey 1982). Members of the reception meeting team had also been influenced by a body of previous literature which discusses the profound impact that the process of entering hospital can have on the person's view of him or her self, and also on their relationships with others who are close to them (see for instance, Whittle 1996). As discussed in chapter 2 of this thesis, this previous literature suggests that the bonds of relationship which tie the person to their significant others may be disrupted or strained as a consequence of the hospitalization (Scott 1973). If the meeting was delayed too long, it was also believed by members of the reception meeting team that opportunities for staff and families to share information and collaborate together might be lost. Relatives might consequently be left with a sense that their opinions and needs were unacknowledged by staff, leading to feelings of dissatisfaction and resentment.

The idea of a reception meeting was therefore usually raised at the point of admission by a member of nursing staff with the service-user and any family members or significant others who were present, and information leaflets about the meeting were provided, (see Appendix 2). It was recognized by the reception meeting team that convening network meetings in an agency setting where more traditional, individually-orientated approaches predominate can be a complex and sometimes difficult activity (Burnham 1986). Staff might feel insufficiently trained or experienced, and service-users or relatives might greet the invitation with suspicion, particularly if they have been in contact with psychiatric services over a period of time and this is the first time that a meeting of this sort has been suggested. By having written information available, the reception meeting team therefore hoped that the process of convening would be simplified and the meetings demystified for those people who were invited to attend.

The reception meetings were usually planned as 'one off' events, rather than a series of network meetings occurring during the period that the individual remained in hospital.

During the data-collection phase of this research there was, on average, about one reception meeting per week on the Unit: clinical records indicate that a total of 85 reception meetings occurred between January 1998 until July 1999 (approximately 4.5 per month). The regularity with which the meetings occurred was not evenly spaced, however, and on some weeks several meetings occurred while at other times there was a relatively long interval between meetings.

Composition

When seeking permission from the service-user to arrange a reception meeting, the nurse who was carrying out the hospital admission process would also usually enquire about who it might be useful to invite. As well as any family members or 'significant others' who the service-user felt should be invited, the meeting would also be attended by members of the professional network, which might include: member(s) of the Unit staff team; any community-based professionals who were involved in the situation (or who might become involved when the person was discharged, if there was no current involvement); and members of the reception meeting team who hosted the discussion.

The practice of convening this network of people together was influenced by the systemic concept of the 'problem determined system' (Anderson & Goolishian 1998). Anderson and Goolishian conceive of human systems linguistically; that is, rather than viewing problems in structural terms as arising through malfunctioning relationships within a family or group, a 'problem' system is regarded as a conversational or meaning system. From this perspective, 'the problem' does not exist as an entity, *"in the wild, all by itself"* (Hoffman 1993, p.41); rather, it is considered to be constructed in language between people. Drawing upon this idea, the 'problem determined system' comprises the network of conversations that occur about the problem. This necessarily included the contributions of members of staff from the Unit since this 'conversational system' expands to include the hospital team when admission has occurred.

From a social constructionist perspective, it was not essential that all of those who were connected with the problem situation physically attended the meetings, since this 'problem system' is not a collection of people but a network of ideas or conversations (Anderson 1997). There were, however, implications for the kind of conversations that could occur in some instances if 'key' individuals were not present, particularly in

relation to decision making within the meetings (for instance, discussions about altering medication might occur even if there was no doctor present, but decisions about this could not be taken since other staff do not have the authority to prescribe). There was a number of factors which might influence attendance at the reception meetings, including, for instance, the wishes of the service-user, the willingness of family members or significant others to participate, competing demands on staff time, and staff perceptions of the value of attending. This issue of attendance at the meetings, and the implications of this for the conversations that occurred is further explored in chapter 8.

Summary

The purpose of this chapter has been twofold: firstly, to provide a picture of the research site in order to orientate the reader towards the organizational system in which the reception meetings occurred. A number of complex issues facing psychiatric admissions units nationally were identified, and the general psychological and emotional climate of the research site during the period of data-collection was discussed. Secondly, the reception meetings which are the primary focus of the study were discussed in more detail than has been provided previously, including an account of some of the guiding theoretical ideas and practice principles which influenced the manner in which the meetings were facilitated or 'hosted' by the reception meeting team.

The discussion that occurred in this chapter therefore provides an important contextual background for the discussion that follows in the next three chapters regarding the overall methodology and design of the study (chapter 4) and the specific methods that were employed for data-collection and analysis (chapters 5 and 6). In chapter 4 the postmodern orientation of this study will be discussed, with a particular emphasis on the related systemic and social constructionist ideas which I have drawn upon both as a researcher and a practitioner. Operationally, the research will also be located within a practitioner research tradition.

Part two:

Methodology and methods

Chapter 4. Research Methodology

Silverman (2000, p. 88) defines 'methodology' as *"a general approach to studying research topics"*, and suggests that the methodology selected by the researcher shapes the overall study design, including which methods are used as well as how each method is used. In this chapter I will present the methodological framework which informs this research, prior to a discussion in the chapters that follows regarding the specific methods for data collection and data-analysis that I employed in the study. Prior to discussing the research methodology, however, it is useful to revisit the broad preliminary aims of the research as articulated in the introductory chapter of the thesis. These broad aims were inevitably subject to a degree of revision after I had undertaken a substantial analysis of the relevant literature, (see Chapter 2), and particular themes and areas for further enquiry were highlighted.

Aims and guiding propositions for the study

The preliminary aims of the study were:

1. To explore the perceived meaning and significance of the reception meetings for participants through the narratives told about them.

2. To develop an account of the interplay between different forms of communication that occurred in the reception meetings. In particular, the research aimed to consider whether participants in the reception meetings experienced the communication that occurred as participatory and dialogical in nature or rigidly monological and impositional.

3. To consider the relationship between the reception meetings and the organizational context of a psychiatric admissions Unit.

4. To consider the implications for future practice

This initial formulation of the research aims invited a primary focus upon participants' experiences of voice in the reception meetings; that is, whether the meetings were felt to have been occasions for dialogue with opportunities for speaking and hearing of different

stories to occur, or were monological in nature with participants feeling that their voices were stifled, (aims 1 and 2). Questions about the implications for practice development of the stories told through the research were also a central concern, (aim 4). These preliminary aims continued to be highly relevant to me after undertaking the literature review for the study, since problems associated with poor communication between families and staff which were characterized by mutual isolation and distance were frequently highlighted in the previous literature (see, for instance, Whittle 1996). In addition, literature from Finland regarding social network meetings (Seikkula 2002) supported the idea that the reception meetings might be helpful in addressing these difficulties by offering a forum in which open dialogue could occur between service-users, family members and staff.

Close reading of the Finnish literature did, however, highlight a key area that had been largely omitted from previous discussions. There was relatively little consideration of relationships of power within psychiatry, and the difficulties associated with generating dialogue in a power-saturated social field where relationships are markedly asymmetrical. The power invested in staff includes both formal powers (for instance in relation to the Mental Health Act (1983), or the power to forcibly administer medication), as well as informal powers associated with the authority invested in professional voices. Within a psychiatric context, the professionals are authoritative story-tellers while the service-users accounts are frequently considered to be less authoritative or valid (Andrews et al. 2000). In addition, there are hierarchies of power between staff from different professional disciplines, creating further potential obstacles to dialogical patterns of communication. It was therefore a guiding proposition for me in the study that the absence of discussion regarding issues of power and authority within the Finnish approach was a marked omission, and raised questions about the transferability and relevance of the approach for use within a UK service context. The importance of the third preliminary aim of the study, concerning the relationship between the reception meetings and their organizational context, was therefore reinforced through the process of reviewing this literature. The relevance of a research design through which I could engage with the multiple voices of service-users and family members was also underlined, as there was no published research where the perspectives of participants were included. This absence of participants voices in the previous literature was a key omission in elation to an approach concerned with voice, and therefore inevitably, with the relationship between perspective and power. In relation to the third aim, a subsidiary question was therefore raised:

- *How does the social position that participants occupy within the research site, (service-user, family member or professional) influence the extent to which they felt able to give voice to their concerns, (and to be heard by others).*

The process of reviewing the previous literature also brought home to me that the reception meeting team had been more ambitious than I think we initially realized in our plans to implement the meetings in a hospital setting. Discussions within the literature of previous attempts to implement family-based approaches in in-patient units stressed the difficulties that are likely to be encountered, (see, for instance, Treacher 1984). Again, discussion of thorny organizational issues was largely absent from the Finnish literature, and a further subsidiary question associated with the third aim was therefore:

- *What are the specific obstacles or barriers associated with the process of implementing network meetings in a psychiatric hospital setting?*

In other words, I became increasingly focused upon the organizational development implications of the research.

In the discussion that follows the postmodern methodological stance that I adopted as a researcher will be considered. Postmodernism invites a focus on social processes, language, voice and power and this methodological position was therefore extremely congruent with the research aims.

The methodology

This research developed out of my interest as a systemically orientated practitioner in the ways in which systemic ideas might inform practice in a psychiatric in-patient unit. Concepts and ideas associated with contemporary systemic practice therefore constitute the theoretical landscape for both the practice which is examined in the research and for the research design itself. In recent years postmodern and social constructionist ideas about the role of language in creating our social worlds have been particularly influential within the field of systemic practice (Dallos & Draper 2000) and also within qualitative research (Denzin & Lincoln 1998). In the discussion that follows I will therefore locate this research

within a postmodern framework since these ideas have inspired and provoked me through every phase of the process.

Postmodern, systemic and social constructionist perspectives

'Postmodernism' is a rather slippery term, defying precise definition (Stevenson & Reed 1996). Rather than representing a single body of theory, it can be conceived of as an umbrella term which includes a range of theoretical "camps" which share in common a focus on the constructive nature of language and a scepticism towards a realist position regarding an external world which can be directly accessed or 'found' through research (Pearce 1992). The theoretical positions or "camps" which have particularly influenced my thinking in the design of this research, are systems theory (Bateson 1978), and social constructionism (Gergen 1985).

The term 'postmodern' has been used both to identify a particular period, (although the exact period which is encompassed has been the subject of dispute) and to describe a cultural, aesthetic and philosophical movement. As an intellectual movement, it has its centre of gravity in art, architecture, literature and cultural studies rather than the social sciences, but the influence of postmodern thinking has spread across a wide range of disciplines (Burr 1995). Because the term eludes precise definition, Lather (1991) suggests that it should be pluralized in order to encompass the various positions identified as 'postmodern'. Through the prefix 'post' it defines itself in relation to what it comes after, a transitional point on, *"the boundary between the 'not yet' and the 'no longer'"* (Blumenberg, cited in Lather 1991, p. 87).

The 'no longer' which postmodernism refers to is the project of modernism, which dates from the mid-eighteenth century, the era frequently described as the 'Enlightenment' (Burr 1995). The modernism project was characterized by the search for truth and an understanding of the true nature of reality, and driven by belief in reason, rationality and progress. The progress of scientific knowledge, according to the modernist view, allows us to understand the world in a value-free manner, and to predict, and control events within it to the ultimate benefit of humanity (Lather 1991). Key assumptions are that knowledge can be grounded in absolute, objective truth, and that what can be known is independent of the knower.

The modernist project is characterized by a search for the underlying structures or deeper meanings of events which lie beneath surface appearances. According to this view, some people will accumulate objective knowledge about the world, understanding more about its workings than the majority, and will therefore understand how to correct things when they go wrong (Pocock 1995). The idea of accumulated objective knowledge about deeper, underlying structures leads to the production of 'grand narratives' or 'metanarratives': large scale 'theories of everything' which offer a way of understanding the entire social world in terms of a few all-embracing principles (Burr 1995). In the field of sociology, for instance, Marxism provides an analysis of society in terms of underlying class-conflict, while in psychology Freud posited the notion of the unconscious as the invisible, underlying structure of mental life. Accompanying these metanarratives are ideas of universal 'essences' or 'absolutes' which stand outside of history and culture; for instance, essentialist notions of a psychological 'core self', ideal forms of family structure, innate gender differences, unquestionable moral rules (Reed & Ground 1997). Research, from a modernist perspective, is a way of uncovering 'objective' knowledge about the area being studied, with rigorous method leading to a 'truer' understanding of events (Gergen 1985). This philosophical position, known as positivism, which suggests that research can uncover 'truth' by following a general set of rules of method which are applicable regardless of context, is problematized by postmodernism. Within postmodern research the notion of a direct correspondence between knowledge and external reality is replaced by a focus on the social and linguistic construction of our perceived worlds, and a concern with multiple ways of knowing and multiple truths (Kvale 1995). A multiplicity of perspectives allows for the development of a richer or "thicker" description of the phenomenon which is being explored (Geertz 1993). In relation to this study, my aim was to draw upon the multiple perspectives of the research participants to generate an account of the reception meetings which is complex, nuanced, and hopefully stimulating, rather than to arrive at an 'objective' account of what took place in the meetings, or to 'decode' any hidden dynamics or deeper structures associated with them.

The meaning(s) of the prefix 'post' in the term post-modernism, and how post-modernism is positioned in relation to modernism is open to multiple interpretations, but a questioning of the grand narratives of modernity is a defining feature of post-modernity (Lyotard 1992). For Lather (1991), the project of modernism is "exhausted". We are now, Lather contends, in a post-positivist era where the "dinosaur culture" of modernity with its master narratives

has been displaced by conceptions of knowledge as being partial, fragmented, and inevitably value-laden (Lather 1991, p. xvi). Discussing post-positivist research, Lather argues that it should be reflexive in character, recognising that the investigator's values inevitably enter the investigation. Lather contends that such research should be self-consciously ideological, a form of "passionate scholarship" which aims to empower or improve the social world.

A different and less oppositional account of the relationship between modernism and the postmodern is provided by the architect Charles Jencks (1992), a leading commentator on the subject. Jencks proposes that rather than succeeding modernism, postmodernism stands alongside it. For Jencks, postmodernism is a hybrid, "double-coded" term which encompasses both the continuation of the modernist project and also its transcendence. The great meta-theories associated with modernism continue to have a place, but it is a more limited one. Jencks argues the goal of postmodernism is to further pluralism and to overcome the elitism associated with modernism. The modernist narrative is seen as simply a narrative which is currently dominant, but it is not the only possible story (Reed & Ground 1997). The postmodern world is therefore one which can no longer be understood by reference to a single, over-arching system of knowledge and which emphasizes the co-existence of a multiplicity of narratives and ways of life.

Fox (1997) suggests that the mood of postmodernism is explicitly political, and that much postmodern writing is underpinned by political commitments to resistance and to challenging the marginalization of the 'dispossessed'. The political implications of postmodernism have been a subject of dissent, however, with some arguing that a focus on language and scepticism towards the material world ignores the structural inequalities that impact upon the lives of oppressed people (Minuchin 1991). A counter argument is that by focusing on language, postmodernism contributes to an understanding of the interrelationship between 'knowledge' and 'power', of the part placed by language in the construction of social realities (Fox 1997). Within the mental health field a number of commentators have drawn attention to the political dimensions of language, that the act of naming or diagnosing is an act of power (Gergen, Hoffman & Anderson 1996; Laing 1967). Within this study the adoption of a postmodern perspective was therefore extremely valuable in raising questions about the research participants' experiences of voice and the microprocesses of power within the reception meetings. This was a key area of inquiry,

since one of the aims of the reception meetings was to create a forum in which collaborative, dialogical exchanges could occur between service-users, family members and staff.

To speak of the development of a postmodern world-view and the "exhaustion" of modernism (Lather 1991) implies that this pluralistic world-view has replaced the authority of modernism. This is far from the case: the contemporary emphasis on evidence-based health-care, and the dominance of the random-controlled trial as the 'gold standard' for producing reliable and legitimate knowledge (Muijen 2003) suggest that rumours about the death of modernism are greatly exaggerated. If the term 'modernism' is used to signify a period in history when the world was thought to be knowable in a direct, unmediated way, then, as Birch (1995, p. 220) comments, *"plenty of people live back then right now"*. One of the dilemmas explored in this study was concerning how to introduce postmodern practices which were orientated towards ideas of multiplicity and uncertainty into an agency where modernist notions regarding the importance of the professionals determining the correct diagnosis and then applying the appropriate treatment constituted the taken-for-granted reality.

Postmodern ideas have shaped the overall aims of this research, which is concerned with generating a qualitatively rich and nuanced account of the reception meetings by including the multiple voices of service-users, family members and professionals who took part in them, rather than arriving at any final, authoritative and 'objective' conclusions about 'what happened'. A number of researchers who are sceptical towards positivism have proposed alternative criteria for assessing the validity of research reports, and borrowing from these writers, my aspirations for this study are to generate an account which is interesting and stimulating, and which allows practice to be seen in new ways (Gergen 1985), and which is also useful in stimulating practice development (Annells 1999).

The systemic perspective

Postmodern ideas have also been strongly influential within the field of systemic practice in recent years, ushering an increasing emphasis within the field on language, multiple realities and the impossibility of gaining direct, unmediated access to the external world (Anderson 1997). The attraction of postmodernism for many systemic practitioners is not surprising since there are strong 'family resemblances' between several of the key ideas associated

with the systemic approach and postmodernism[1]. A focus on the importance of language in shaping social realities has been characteristic of the family therapy and systemic practice field since its earliest days, for instance, alongside an interest in how the different perspectives of social actors in a particular situation become constructed through the micro-processes of interaction (Burnham 1986).

A central premise of systemic theory is that the world that we live in is a world of communication (Cecchin 2000). Communication is a primary social process, and it is in communication with others that we develop our individual identities and our understandings about the world. In systems theory this focus on communication entails a shift away from the narrowness of individually based descriptions of human behaviour toward an understanding of the significance of interactional processes (Dallos & Draper 2000). Simplistic explanations for why people behave in the way they do involving linear causal theories are replaced by the idea that we exist within circular, recursive patterns of mutual influence.

Drawing upon a systemic perspective, Pearce and Walters (1996) have described research as essentially an act of communication. The research project is conceived of by these authors as the nexus of a cluster of overlapping conversations. The number of conversations that could potentially occur in relation to a given topic is infinite but not all conversations are equally important as components of the research process, and researchers make ethical and pragmatic choices about which conversations to include and which are omitted. In this study, for instance, the cluster of 'pertinent' conversations included:

- Conversations with service-users and family members or significant others
- Conversations with staff in the Unit
- Conversations with community-based staff
- Conversations with members of the reception meeting team
- Conversations with service managers and lead professionals
- Conversations with University supervisors & the academic community
- Conversations with other systemic practitioners

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[1] Flaskas (2002) emphasizes the diversity of ideas associated with the term 'postmodernism'. Within the field of systemic family therapy, however, she argues that understandings of postmodernism have tended towards homogeneity, possibly because of the practice basis of the discipline. My own background as a systemic therapist has strongly influenced the account of postmodernism provided in this thesis, which is shaped by those themes which are more frequently discussed in the systemic literature.

Pearce and Walters (1996) comment that the complexity of the research process is inevitably underrepresented in any written account of the project that is produced, but that researchers can be more or less transparent about which conversations have been privileged and which left out, and can also select research methods that attempt to acknowledge or address this complexity rather than to circumscribe it.

An emphasis on contextuality is a feature of systems theory, and according to Harre (1997), is generally characteristic of the postmodern approach to understanding human life. The concept of contextuality proposes that the meaning of any act will be at least partially derived from the context in which it occurs. The accounts provided by research participants within qualitative research interviews, for instance, cannot be regarded as straightforward factual reports on reality, but will be infused with different shades of meaning according to a range of factors including the physical and social contexts of the interview, and the perceived nature of the relationship with the researcher (Kvale 1996). The stories told by research participants in this study therefore cannot be separated from the context in which the interviews occurred, (usually a hospital ward), and the interviewee's perceptions of me as a researcher who is also a white, male, middle aged professional and who occupied a position as a senior practitioner within the agency. From a systemic perspective, these aspects of the research relationship are not 'variables' that can be excluded or controlled since any story told is contingent upon the moment and context of its telling. Systems theory therefore provided an important contribution to the methodology of the study, raising questions about how the narratives that were generated through the research process were influenced by these contextual factors. These questions included, for instance: what stories were told by participants because of their experience of me as a practitioner as well as a researcher?; what stories remained untold because of my position within the agency that might have been told to an 'outsider' researcher who did not have an ongoing professional role in the agency? These questions will be returned to in chapter 13 where the discussion focuses upon re-viewing the research process.

Within systems theory there is a concern with multiple perspectives or multiple versions of reality which is also characteristic of postmodern theories more generally (Gergen 1991). Events are inevitably perceived or 'punctuated' (selected, organized, privileged) differently by the various participants in any social situation, and these different punctuations are both a potential source of conflict or problem-maintaining sequences of interaction, and also a

resource for change (Jones 1993). None of these different punctuations is more 'true' than another, since we can never have direct, unmediated access to the world 'as it actually is'.

The focus on perception and differing punctuations has also led to an increasing interest within systemic practice on the way that the observer participates in that which is observed (Jones 1993). We can never create neutral, unbiased descriptions of the world as researchers or practitioners. In the act of describing, we contribute to the creation or re-creation of the phenomenon we describe. In discussing the position of the researcher within research, Denzin & Lincoln (1998, p.26) cite the systemic theorist Gregory Bateson's proposition that all human beings are guided in their actions by highly abstract principles. These principles include beliefs regarding ontology, (about the nature of reality and about what kind of being is the human being), beliefs about epistemology, (about what is the relationship between the inquirer and that which is known), and about methodology, (how we gain knowledge about the world). These different beliefs form an interpretative framework through which the researcher views the world and acts in it. The researcher is therefore *"bound within a net of epistemological and ontological premises which- regardless of ultimate truth or falsity- become partially self-validating"* (Bateson, cited in Denzin & Lincoln 1998, p. 26). From a systemic perspective, all research is therefore interpretative, and will be shaped by the beliefs of the researcher. As researchers we are required to try to reflexively understand our own understandings, and the patterns and meanings that we inevitably impose on that which we interact with (Singer 1995). A systemic focus of the recursive relationship between the researcher and that which is researched was particularly important within this study, since I already had a complex relationship with the research site as a senior practitioner prior to commencing the research, and held what were sometimes strongly formed beliefs about the Unit and about many of the people involved in the service. Drawing upon systems theory in the development of the research methodology was therefore useful in emphasizing reflexive processes, thus inviting me to revisit my own beliefs and understandings so that these might be altered, expanded or transformed through the process of inquiry.

Like Bateson, Pearce and Walters (1996) have also drawn attention to the interpretative nature of research, and describe the researcher as being in a co-evolving relationship with the people or situations being studied. As the researcher develops an understanding of what they are studying, s/he also changes, and so what they bring to the research process alters. Pearce and Walters go on to say that the very presence of the researcher also changes the

manner in which members of the observed system act. The extent of this change may vary, but Pearce and Walters (1996) argue that in studying living systems, the researcher must expect that their presence has some influence. While this phenomenon of observer influence might be regarded as problematic if considered from a positivist perspective, the idea of research as being, at some level, an intervention within the system being studied is rich with possibilities from a practitioner research perspective, where one of the explicit aims is to act as a catalyst to new practice (Reed & Procter 1995). One of my aspirations for this study was that it might enhance my own practice and act as a stimulus to the work of other practitioners in the mental health field, so the adoption of a systemic perspective which conceptualises research as a form of intervention within systems was highly congruent with this aim.

Social constructionism

Systemically orientated researchers and practitioners have increasingly become drawn towards social constructionist theories in recent years (Hoffman 2002). This may be because social constructionism contains a number of premises which offers a more sophisticated account of power than is provided by systems theory (Hoffman 1993). The concept of power has been a controversial one within the systemic field since its beginnings (Carr 1991). Gregory Bateson, a key figure in the development of systems theory, famously argued that power is a dangerous myth which obscures understanding of the recursive nature of systems, while his colleague Jay Haley disagreed, stating that it is characteristic of human relationships that one party attempts to influence the other (Carr 1991). For systemically orientated researchers and practitioners, social constructionism provides a way forward from this polarized debate about power, since constructionism is concerned with the ways in which our local realities are shaped by (and, to a lesser extent, give shape to) dominant socio-cultural discourses and the interrelationships between voice and power.

Constructionist writings frequently focus on story or narrative as a primary means for giving meaning to our lives (Murray 1989). Our personal and social identities are constructed through finding stories to tell about ourselves, so that it can be said that *"when we understand someone, we understand his or her stories"* (Keen, cited in Murray, 1989 p. 178). The stories that we tell about ourselves are constructed and re-constructed through our communication with others, as we participate together through joint actions in the creation of our social world (Shotter 1993).

Shotter (1991) argues that the focus on narrative within social constructionism allows the researcher to encounter the 'first person voice' of the people they converse with in interviews, and for the research participants to communicate *"what it is like **to be** them"* (p. 105, original emphasis). In providing an opportunity for the researcher to understand something of the unique world of individual research participants, Shotter contends that social constructionism provides a more useful and ethical framework for both research and clinical practice than systems theory, which tends to concentrate on recursive relationships **between** people but is less attentive to the complex subjective realities of the individuals involved.

The stories that we tell about ourselves as individuals are derived from a multitude of sources (Pearce 1994). Some stories become dominant within society because they are promoted through the media, for instance, while other cultural and ethnic stories are favoured within particular communities or are handed down through generations; some stories become dominant within particular organizations or amongst different professional groups; others are derived more from our individual life experiences. Weingarten (1995) argues that it is difficult for individuals to tell stories that divert from the narratives that are dominant within a given organization or society. Some stories are legitimised within particular cultures while others are denied, trivialised or otherwise marginalized. The stories that we tell about our lives are therefore derived from theses cultural repertoires, and when there is dissonance between our experience, our stories lived, and the available range of culturally legitimised stories that we might tell, then our individual voices may be silenced.

This theme is developed by Cecchin (1993), who discusses how identity becomes formed and restricted by the positions that individuals occupy within particular systems. We may become, over time, "prisoners" of these socially constructed identities:

"Of course it is necessary and also comfortable to have an identity but you are at risk of becoming its prisoner if you begin to belong exclusively to any kind of system. The whole system will then support and reinforce your chosen identity thus helping you to stay and be stuck in the same position". (Cecchin 1993, p.3)

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The stories that we tell about our ourselves and the stories told by others about us as individuals can therefore become increasingly restricted by the systems that we inhabit, and by the dominant narratives about what it is to be a person occupying that particular role in that kind of organization or system. Discussing the impact of cultural stereotypes on our individual lives and relationships, Birch (1996) observes that our lives are often lived according to these stereotypes unless we remain alert to them. A particularly powerful set of stereotypes surround the mental health field, with images of psychiatric service-users circulating within society which are unflattering, garish, and at times frankly oppressive in nature (Johnstone 1994). The stories told by participants in this research will therefore inevitably be influenced by the specific positions that the different individuals occupy within the psychiatric system, such as service-user, relative or mental health professional. One of the aims of the reception meeting team was that the reception meetings might be a forum in which dialogue could occur between the different participants (Reed, Stevenson & Wilson 1998). Dialogue entails the participants speaking from more personal positions and engaging with a multiplicity of voices rather than the narrow dominance of authorised accounts (Good 2001; Seikkula 1993).

Focusing upon narrative and the metaphor of voice invites, according to Oliver (1996) a concern with how talk is put together; that is, a focus on position and on power. Thinking about voice, Oliver suggests, raises questions such as *"What place is the voice speaking from? Who is speaking to whom? Who is speaking most / least loudly? What could be said about ineloquence (the not said)?"* (Oliver 1996, p. 249). This idea of the interrelationship between voice, story and power has been further elaborated by Pearce and Pearce (1998) in their analysis of the ways in which events and objects in our social world are constructed and re-constructed through ongoing patterns of interpersonal communication. These authors are concerned with the actual processes of storytelling; the abilities and circumstances required by people in the creation and telling of particular types of story. In considering the interrelationship between meaning and action, and how particular narrative accounts are made, Pearce and Pearce offer the notion of stories **lived** and stories **told**:

"Stories lived are the co-constructed patterns of joint-actions that we and others perform; stories told are the explanatory narratives that people use to make sense of stories lived". (Pearce & Pearce 1998, p. 171).

Pearce and Pearce suggest that in our lives we are involved in an ongoing process of bringing these stories lived and stories told into alignment. We tell stories in such a way as to create coherence in our lives. There is, however, an inevitable tension between the two, and Pearce and Pearce propose that this tension provides impetus for change and creativity, as well as for conflict. Examining the processes of storytelling invites us as researchers to consider both the richness of any particular communication pattern, and also the processes of power which are in play and which shape the types of storytelling that occur.

In considering the power relationships implicit in the activities of living and telling particular stories, Pearce and Pearce (1998) have developed what they describe as the 'LUUUTT model', which locates the position(s) of particular stories within our lives as we shift between different contexts. LUUUTT is an acronym for:

- stories **L**ived
- **U**nknown stories
- **U**ntold stories
- **U**nheard stories
- stories **T**old
- story **T**elling

(Pearce & Pearce 1998, p.171)

As well as stories lived and stories told, Pearce and Pearce suggest there are *unknown* stories which participants are not capable of telling at that moment; *untold* stories which participants are capable of telling but have chosen for whatever reason not to tell to particular people in a particular context; and *unheard* stories which have been told but not heard by some important participants in the situation. *Storytelling* is concerned with how the stories are told rather than with their content or place in conversational exchanges. Pearce and Pearce conceive of a spiralling, evolutionary process between these different types of story, as, for instance, unheard stories become untold stories, and untold stories then become unknown stories.

Implications of the methodology for the research questions

Kvale (1996) comments that the positivist image of the researcher as a miner digging for nuggets of 'pure knowledge' is problematized by postmodernism, which has ushered a loss of faith in the idea of an external world that can be directly accessed. The emphasis within postmodernism on the constructive nature of language unseats the modernist idea of scientific models and knowledge as a "mirror of nature". Instead, knowledge is regarded as a social accomplishment, a matter of conversational and social practices, according to the philosopher Richard Rorty (discussed in Kvale 1996). Within systemic and social constructionist frameworks, conversation is the primary activity through which we create our social worlds and our understandings of ourselves and others. Conversation is not simply one of the many activities that we engage in, it is the usually ignored or taken for granted background against which we constitute ourselves as human beings (Shotter 1996).

An emphasis on research as a conversational process, along with a postmodern focus on the inter-relationship between voice, story and power has shaped the sorts of questions that I have aimed to explore in the study. A concern with voice raises questions not only about the stories that people tell about their experiences, but also about power, about how particular contexts encourage or suppress different voices. The research questions in this study therefore relate both to participants experiences of the reception meetings and also what Oliver (1996) refers to as matters of eloquence or ineloquence: the extent to which participants felt able to speak and be heard in the meetings.

These questions about the extent that those who participated in the research felt able to speak, to be heard and to listen to the voices of others within the reception meetings have particular resonance in an in-patient psychiatric setting where attempts to foster genuine dialogue between the service-users, families members and professionals may be plagued with difficulties. Staff hold great power in these contexts and the voices of the service-user and their relatives may be stifled in the face of this professional authority (Stevenson & Reed 1996). Similarly, the processes of receiving a psychiatric diagnosis or being close with someone who is identified as 'mentally ill' can result in social disqualification and a resulting loss of voice for the people concerned (Reed 1999)

Conceptualising the research in systemic and social constructionist terms as a cluster of overlapping conversations influences not only what questions are asked, but also how they are asked, inviting a shift towards dialogue and the negotiation of meanings (Kvale 1996). This implies a more engaged researcher position rather than the 'disinterested observer' position associated with a positivist philosophy (Pearce 1992). In the next section of this chapter I will go on consider some of the 'operational' considerations that follow from adopting a postmodern epistemology. In particular, I will locate the study in relation to the fields of action research and practitioner research, since these research approaches favour a more engaged researcher position, in which the researcher aims to develop practice or generate social change. My initial desire to undertake the research was stimulated by my struggles as a systemically-orientated mental health practitioner who, together with a group of like-minded colleagues, was interested in learning more about how systemic and social constructionist ideas might be applied to make a positive difference for service-users, families and staff within our service. I will therefore consider developments in the field of practitioner research and its close relation, action research, which have influenced the design of the study.

Action research and practitioner research

Miller and Crabtree (1998) argue for an increased dialogue between researchers and practitioners, and for research activity which focuses on questions that arise from clinical experience. Such research, according to these authors, attends to the underlying assumptions and values which shape clinical encounters, and will produce 'results' or 'findings' which are aimed at, and accessible to, practitioners. The aim of this type of research is therefore to produce situated knowledge, knowledge from "somewhere in particular" which is rooted in the concerns and needs of the practice world.

Conquergood (cited in Pearce & Walters 1996) has also challenged the traditional 'pure vs. applied' division within the research field. He argues that the distinction itself is located within a discourse which excludes the 'practical' from the 'theoretical', and in which 'applied' work is already judged to be inferior. Conquergood proposes that the choice is no longer between 'pure' and 'applied' research, but between research that is 'engaged' or 'complicit':

"By engaged I mean a clear-eyed, self-critical awareness that research does not proceed in epistemological purity or moral innocence. There is no immaculate perception" (cited in Pearce & Walters 1996, p. 15).

Writing from social constructionist positions, Pearce (1992) and Shotter (1993) similarly propose that researchers should *join with* the processes that they study, so that they can gain a kind of "knowledge from within". This form of knowing arises from the researcher adopting an engaged position and being in dialogue with others, rather than a more distant (and potentially distancing) "knowing about". There are a number of research traditions which invite this kind of participatory approach, including action research and the more recently developed field of practitioner research.

Action research

The concept of action research has its origins in the work of the social psychologist Kurt Lewin (1946), who argued that it was necessary to apply ideas from the developing field of the social sciences to pressing community problems. Lewin (1946, p. 34) argued that, *"research that produces nothing but books will not suffice"*, and believed that social change can be achieved through action research. He also contended that action research generates situated, context-sensitive knowledge which is particularly relevant to the needs of practitioners and community leaders, as well as to policy makers who are concerned with developing and implementing strategies for addressing specific problems.

Action research entails collaboration between researchers and practitioners with the aim of finding solutions or creating changes which are relevant to the needs and requirements of a particular set of local circumstances (Hart & Bond 1995). Because of its participatory and situation-specific focus, in action research the relationship between theory and practice is seen as dynamic, interactive and constantly evolving. The present study has some of the characteristics of action research, in that the practice that is being examined was a collaborative venture between myself and a group of colleagues, and in designing the study I was hopeful that the research process would enhance my own practice as well as generate theoretical narratives which will be of value to others who are also working in this field.

It would not be accurate to describe this study as an example of 'pure' action research, however, as there are aspects which depart from this tradition. Firstly, although the area of

practice that is explored in the research was undertaken as a collaborative venture, the research itself is more specifically 'owned' by me. In general terms, the practice which is being explored in this study occurred as a result of a group of practitioners collaborating together, while the research is a related, but individual enterprise. A second way in which the research departs from being 'pure' action research is that I was employed as a practitioner within the research site at the time that the data was collected, and it is therefore my own practice which is being examined, along with that of my close colleagues. In this respect the study might therefore be more accurately be described as an example of 'insider' practitioner research (Reed & Procter 1995). Action researchers may or may not be from the same professional field as the research participants, but are frequently 'outsiders' in the sense that they are employed externally and are aspiring to work as partners with the people in the research site. Action research therefore requires that the researcher becomes closely engaged with the research participants and the field of enquiry. One of the central differences between action research and practitioner research is that in the latter the researcher is usually an 'insider'; that is, a practitioner who is undertaking research into their own and their colleagues practice. Close examination of the position of the researcher and roles and relationships with the research participants is therefore particularly characteristic of practitioner research (Reed & Procter 1995).

Practitioner research

Reed and Procter (1995) describe a continuum along which researchers may potentially be positioned in relation to the field of study, from 'outsiders' who have no direct experience of the area being studied, through to 'insiders' who are researching their own practice and that of their colleagues, (see figure 1).

RESEARCHER POSITIONS		
'OUTSIDER'	'HYBRID'	'INSIDER'
A researcher undertaking research into practice with no professional experience	A practitioner undertaking research into the practice of other practitioners	A practitioner undertaking research into their own and their colleagues practice

Figure1: continuum of researcher positions:
(from Reed & Procter 1995, p.10)

When the research setting is also the practice setting, as is the case in this study, particular dilemmas are raised about whether the person is participating in a particular activity associated with the study as a practitioner or as a researcher. The practitioner researcher may hold dual or multiple roles in the agency, which are likely to be sources of confusion or tension as well as generating creativity and the potential for rich insights. Reed and Procter (1995) suggest that in the face of these tensions there is a temptation to try and drop the practitioner role in favour of the researcher role, withdrawing into a 'disinterested observer' position. At the same time, they point to a number of advantages that stem from the practitioner researcher position. The practitioner researcher has a prior understanding of the research site and the phenomenon being studied which can guide the study enquiry towards particularly important areas for exploration. Also, while there are some sensitive issues that research participants might possibly discuss more readily with a more neutral, 'outsider' researcher, other participants may speak more freely with someone who is already familiar to them.

One of the potential difficulties faced by the practitioner researcher is that she or he may experience a sense of over-familiarity with the research site, which can prevent them from seeing practice with fresh eyes (Reed & Procter 1995). An emphasis on self-reflexivity within the research process can assist the researcher to revisit 'taken for granted' assumptions which might otherwise become a hindrance to the process of enquiry (Steier 1991). Maintaining a research diary as I did in this study, for instance, enables the researcher to engage in a kind of reflexive conversation with oneself which allows different perspectives to be gained (Silverman 2000).

Practitioner research and service development

Hart and Bond (1995) identify three ways in which practice can be developed through action research and practitioner research: incrementally, in the form of new initiatives, and through further research. In this study the processes of data-collection and the initial phase of data-analysis were intimately woven together with the practice activities of organizing, facilitating and promoting the reception meetings within the research site. This was an inevitable feature of the study, since I was positioned as an active practitioner in the reception meetings as well as being the researcher. My hope was therefore that the research might provide a direct positive influence upon practice in relation to the reception meetings by generating a richer understanding of which aspects of the meetings were experienced by

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research participants as helpful, engaging, stimulating or empowering and which were experienced less positively. This enriched understanding that I gained from engaging with the multiple accounts of research participants might therefore have a beneficial impact upon my own practice, and also on the practice of colleagues within the service. Similarly, I had aspirations that dissemination of the research might lead to similar projects for families being developed in other psychiatric settings locally and beyond, and might also stimulate further practitioner research in this field.

Validity claims for practitioner research

Hammersley (1992) expresses scepticism regarding the arguments which he suggests are most commonly used by advocates of practitioner research in asserting its superiority over more conventional research approaches. According to Hammersley, the case against conventional research, as the argument is most commonly articulated within the practitioner research literature, centres around the following three points:

1. Conventional research is lacking in relevance for practice. That is, research is of value only to the extent to which it serves the needs of a group of practitioners.
2. It is invalid because it lacks a practitioner perspective. The 'findings' of conventional research are less likely to be relevant as the researcher doesn't have a detailed understanding of context issues.
3. It is exploitative. The question of whose interests are served is pertinent in relation to any study, but practitioner research which explicitly aims for social change is arguably less likely to simply promote the interests and careers of the researchers.

Hammersley is dismissive of each of these points. He counters the criticism that conventional research is irrelevant by arguing that knowledge may be either directly or indirectly relevant to practice or policy decisions, and that while conventional research is more frequently of indirect and more generalised relevance, it is no less valuable. Similarly, he rebuts the claim that conventional research is invalid because it lacks a practitioner perspective by challenging the implicit positivist assumption that practitioners have privileged insight regarding what is or isn't a useful contribution to practice. Practitioners will have a distinctive perspective, but not necessarily the 'correct' view. Lastly, in relation to the accusation that conventional research is exploitative, Hammersley contends that it

can't be assumed that practitioner research will necessarily serve the interests of those engaging in it either. Furthermore, he argues that even if researchers are motivated by careerism, it doesn't necessarily follow that what they produce will be of no value.

Hammersley's (1992) analysis of the respective validity of practitioner research and 'conventional' research helps to avoid forming stereotypical assumptions about the value to practice of conventionally designed studies. At the same time, however, He tends to consider the respective virtues of each from a rather polarized position; that is, the superiority of conventional research over practitioner research, or visa versa. An alternative way of viewing the relationship between these different research traditions would be to adopt a 'both / and' position which is appreciative of the different traditions and the contributions they can bring about. The more abstract or generalized knowledge which can be developed through conventional research and the local, situated knowledge produced through practitioner research are both valuable sources of different 'maps' or metaphors which can assist practitioners in navigating the complex territory of practice. In relation to this study, the qualitative research design that I developed was influenced by several factors: it was appropriate to my own 'insider' position as a practitioner in the research site; it was congruent with the systemic, dialogically orientated service that was being explored; and a more exploratory approach was particularly pertinent in relation to a novel service development. This is not to say that the use of quantitative methods would have been invalid as a means of researching the reception meetings, these methods would simply have allowed for different conversational opportunities and the creation of different narrative accounts (Gergen 1985).

Summary

In this chapter I have addressed the two central aspects of the research methodology. Firstly, I examined the postmodern, systemic and social constructionist ideas which shaped the design of this study, and influenced the sorts of questions which I have sought to explore through the research: questions about the research participants experiences of voice, of speaking and being heard within the reception meeting. In the subsequent section the discussion considered the 'operational' implications of a postmodern methodological position, specifically locating the study in relation to the fields of action research and, more specifically, practitioner research. These operational implications include an emphasis on adopting an engaged, 'insider' practitioner-researcher position in relation to the study, with

the explicit aims of developing practice. This chapter therefore provided an overall theoretical and operational context for the discussion that will follow in chapters 5 and 6 regarding the specific methods that I employed to 'collect' and analyze data for the study.

Chapter 5. Methods for data-generation

In this chapter the research methods that I employed in the study for the purposes of 'collecting' the data are discussed. The discussion begins with a consideration of some specific ethical issues associated with the processes of accessing the research site as a practitioner researcher; developing an ethical and appropriate 'sampling strategy'; and the processes of engaging with the people who participated in the study. The issue of confidentiality and the measures taken to preserve the anonymity of participants will also be addressed. Having considered issues of access, confidentiality and 'sampling', the discussion will then focus upon the use of multiple methods as a means of generating data that is polyphonic and multi-layered. The specific methods that were employed are also discussed, and the relationship between the participant observation process that is an inevitable aspect of an 'insider' practitioner research approach and the semi-structured interviews that were undertaken is considered.

Ethical engagement with the Unit as a researcher

My desire to undertake this research was initially stimulated through discussions with the team of staff within the Unit who first conceived of the reception meetings. I then developed a PhD proposal following discussion with potential supervisors at Northumbria University. In 1997 I presented this proposal to senior personnel in the locality mental health services where I was employed, including the General Manager, the Head of Clinical Services, and the Lead Nurse. The proposal gained strong support from these senior figures, who felt that the study focused on an important area for service development. Ethical approval for the study was also gained from the Joint Ethics Committee for Newcastle and North Tyneside in January 1998 following the submission of a research proposal and associated information leaflets and consent forms for prospective participants (see Appendix 1).

Having gained senior organizational backing, the next step was to engage with the Unit as a researcher in addition to my role as a practitioner. It would have been naive to assume that because the research had received support at a senior level it would be welcomed by practitioners at 'ground level'. As Hammersley (1992) has argued, there are multiple ways

in which those who occupy less senior positions in an organization can be covertly uncooperative if they do not wish to participate in a study. The engagement process therefore required careful thought and a number of ethical issues were highlighted regarding consent and the rights of people to participate in or withdraw from the study. My position within the organization as a senior nurse placed me in a potential position of authority in relation to members of the nursing team, as well as in relation to service-users and their relatives. It was therefore important that those involved in the Unit were informed of the proposed study and had opportunities to discuss it.

Discussing ethical dilemmas associated with action research and practitioner research, Meyer (1993) argues that it is difficult for reluctant staff to opt out of an action research project, since they will inevitably be affected by any organizational developments triggered by the research. Similarly, Reed (1995) discusses how for a practitioner researcher, the activities of 'data collection' and 'practice' are interwoven; data collection does not end, for instance, when a research interview is closed, since all of the activities that are undertaken as a practitioner in the research site are potentially valuable sources of information. Because the research process does not have fixed boundaries, it is important that others involved in these different activities are aware that the research is taking place. However, Moore and Savage (2002) argue that in complex healthcare settings it is impossible for the researcher to ensure that everyone who is potentially involved in a study can be informed at the same time and to the same extent. Because of the number of people involved in the research site it was therefore useful to think of 'gaining consent' as an ongoing process of negotiation, rather than something which could be dealt with at an early stage and then taken for granted for the duration. As a first step towards informing colleagues I discussed the research in a number of staff meetings, but because of the size of the staff team and the 24 hour shift systems that were in place it wasn't possible to speak directly with everyone concerned. I therefore also wrote to all members of staff individually to inform them of the study. Staff were invited to contact me if they would like to know more about the research, and they were also informed that I might approach them individually at a later stage asking their permission to interview them. It was made clear that they were entirely free to decline to be interviewed. Information leaflets about the reception meetings which included a brief statement about the research were also circulated within the Unit, and made available to service-users and family members on admission, as well as to visiting professionals.

The process of data-collection took place over a period of approximately two years, beginning in late February 1997 when the first reception meetings occurred, and continuing until July 1999. This was the period of greatest activity in relation to the meetings, as in 1999 several of the staff involved in the reception meeting team, (including myself) moved to posts outside of the Unit as a consequence of new service developments across the wider organization.

Confidentiality

There are two factors which made mitigated against me attempting to anonymise the research site within this thesis. Firstly, because of the practitioner research orientation of the study, the Unit concerned was obviously within my own employing agency. Also, the reception meeting approach was a service development which was unique to this particular Unit and it has been discussed in two publications as well as in conference presentations, (Reed, Stevenson & Wilson 1998; Reed 1999). Therefore, although the research site has not been disguised, the identity of individual participants has been anonymised by the customary means of altering names. I have also been careful to present data in such a way that it would be impossible to trace any particular words or deeds to specific individuals. Written and verbal assurances about confidentiality were provided to all research participants.

Research design and choice of methods

The central aim of practitioner research is to enable the researcher and his or her colleagues to understand and develop their practice. While this research design contrasts with the objective, value-free principals associated with quantitative research approaches (Silverman 2000), Reed and Procter (1995) argue that there is nothing to prevent the practitioner researcher from utilizing either quantitative and qualitative *methods* to 'collect' and 'interpret' data, according to which methods are most relevant to the focus and context of the enquiry that is being undertaken (Reed and Procter 1995). Similarly, Burr (1995) and Pearce and Walters (1996) contend that there is no contradiction between a social constructionist methodology and the use of quantitative methods. From a constructionist perspective, qualitative and quantitative methods offer different kinds of conversational

opportunities and constraints, or create different kinds of stories, rather than being superior or inferior.

At the same time, Burr (1995) goes on to state that it is more usual that researchers who adopt a social constructionist methodological position employ qualitative methods. The concern with language, relationship and context which is characteristic of a social constructionist orientation finds resonance with similar preoccupations within the qualitative research field (Denzin & Lincoln 1998). Qualitative methods of data-collection and analysis therefore often allow for understandings of the nuances of social processes and the contextually-situated nature of the accounts that are generated. In this study I have therefore used qualitative methods of enquiry as these were more appropriate to the exploration of a specific social situation in depth (Denscombe 1998).

The use of multiple methods is also characteristic of qualitative research, and Denzin & Lincoln (1998, p. xi) refer to the qualitative researcher as *"bricoleur"* who produces a range of knitted together strategies or tools to produce a solution or generate an understanding of a specific, concrete situation. The particular methods or tools that are used depends upon the questions that are asked and the context in which the study occurs. In this study I have employed a range of methods of data 'collection' which were congruent with my own position within the research site, as well as the dialogical ethos of the research. The use of tools such as a research diary and observational notes (see Appendix 3 for examples), was congruent with my situatedness as a practitioner researcher within the field, while the use of semi-structured interviews provided an opportunity to converse in depth with participants occupying different social positions (service-user, family member and professional positions). By allowing for greater sensitivity to contextual factors this use of multiple methods engenders *"a better fix on the subject matter at hand"* (Denzin & Lincoln (1998 p.3). Similarly, Bateson (1988) offers the notion of 'binocular vision': when we look at an object through one eye, the experience of depth is missing, it is when we observe through two eyes that we gain this. It is important to stress that Bateson's concept of binocular vision is concerned with achieving a richer or more complex view by holding two pictures side by side, rather than with achieving a 'true' or 'correct' picture of events through triangulation (Shotter & Katz 1999).

In this study, data was generated from a range of sources and through the use of a range of methods with the aim of enriching the picture that is created. The primary data collection method was a series of semi-structured interviews with people occupying different social positions (service-users, relatives, professionals); but a range of subsidiary methods were also used, including participant-observation; a personal journal in which I have recorded my own thoughts, ideas, and reflections; and also the collation of written texts about the network meetings (see figure 2 for a summary). The 'subsidiary' data collected from these multiple sources provided important contextual information, adding to and enriching the narrative accounts generated through the interviews.

My position as a practitioner researcher within the research site enabled me to access data from the wide range of sources outlined in figure 2, and to engage in a process of participant observation which was invaluable in gaining a detailed understanding of broader organizational and practice issues which impacted upon the activity of introducing reception meetings into the Unit. Prior to discussing the interviews that generated the 'core' data for the study I will therefore give an account of the process of participant observation that I engaged in as a practitioner researcher.

Personal journal	*Interviews*
An ongoing journal was kept from February 1997 in order to facilitate self-reflexivity in the research process. Journal entries provided an account of my own reflections regarding the researcher / practitioner roles, and my relationships with research participants. These reflections were stimulated by my day to day experiences over the course of the project. *(An extract from the research diary is presented in Appendix 3, part b)*	A total of 27 post-reception meeting interviews were carried out with participants from 12 reception meetings, between May '98 & February '99. Interviewees included service-users, their relatives, professionals external to the mental health service as well as staff from the service, in order to generate multiple perspectives. Most interviews (24) were audio-taped & subsequently transcribed. Written records of the three interviews which were not taped were made immediately following the conversations. People interviewed: • service-users: 9 • partners: 2 • parents: 4 • daughter: 1 • ward nurses: 3 • psychiatrist: 1 • community psychiatric nurses: 4 • student nurse: 1 • social worker: 1 • support worker: 1 *(One full interview transcript is presented in Appendix 3, part a)*
Secondary data	*Data derived from practitioner observation*
Secondary data sources included: • clinical records from the reception meetings • correspondence about the meetings • notes from meetings held within the organization where the reception meetings have been discussed	Data generated in the course of my active participation as a practitioner / researcher in reception meetings, and in the day to day activities of the research site. This data included field notes based on my participation in reception meetings; audio-recording from staff team meetings; and recorded discussions with individual members of staff concerning the reception meetings *(Examples of observational notes made in the reception meetings is included in Appendix 3, part c)*

Figure 2: Summary of sources of data & data collected.

Practitioner observation

Participant observation is a means of collecting data in which the researcher participates in the activities of the group that s/he is studying. It has been described as one of the most important data-collection strategies in practice-based professions (Moore & Savage 2002). The degree of involvement that the researcher engages in may vary across a spectrum from that of a more passive observer who adopts a 'fly on the wall' position, through to complete immersion in the field where the researcher acts as a member of the group at the same time as observing what occurs (Field & Morse 1985). The degree of researcher participation will inevitably shape the data that are collected, since what we see at any moment depends upon where we happen to be standing. While a more detached observer position might be argued, from a positivist perspective, to reduce the risk of researcher 'bias', social constructionist researchers may prefer more engaged, collaborative approaches which provide 'insider' experience and knowledge (Pearce 1992). My own position in this research was, of course, towards the latter end of this spectrum of involvement.

One of the distinctions between participant observation as it is frequently described within the research literature and the type of activity that I was engaged in within this study was my pre-existing familiarity and relationship with the research setting. Davies (1995) suggests the term 'practitioner observation' to describe this method of data-collection within practitioner research. In practitioner observation the researcher's prior relationship with the research site potentially carries both advantages and disadvantages; it is advantageous in that the process of inquiry begins from an informed position, so that the researcher can make judgements early on about what are the important areas to focus on. At the same time, however, this prior knowledge may lead to over-familiarity and a tendancy to miss details which would be more apparent to an 'outsider' researcher (Bonner & Tolhurst 2002). The use of reflexive strategies such as maintaining a research diary were therefore invaluable in assisting me to revisit my own professional assumptions, particularly during the period of data-collection when familiarity might lead me to neglect the importance of particular phenomena or to respond in a more immediate, 'practitioner mode' rather than adopting a 'researcher position' and reflecting on the potential meanings of the episode that was occurring.

Despite the complexities associated with a dual researcher / practitioner role, it also afforded me access to a great deal of important data by allowing for opportunities to observe how the different participants such as service-users, family members, Unit staff and community team members seemed to regard the meetings, (as displayed, for instance, by discussions that took place in clinical meetings, training and business meetings as well as informal conversations in the research site). My practitioner role also provided me with access to a range of secondary data sources such as clinical records of meetings and correspondence or minutes of meetings in which the reception meeting project was referred to. The members of staff who formed the reception meeting team met periodically to review the progress of the project, discuss clinical issues, and formulate new strategies for facilitating the integration of the reception meetings within the wider organizational system. These team meetings were audio-recorded for later analysis, with the informed consent of those present. I also recorded my own observations and reflections in my research diary, which provided a further important method of 'capturing' events in the research site. Data derived from these sources were particularly useful in tracing the evolving narratives about the reception meetings within the service.

This practitioner observation process and the process of research interviewing were recursively connected to one another. Ideas and themes that I developed through participating as a practitioner researcher in the reception meetings and in other day-to-day activities within the Unit were further explored with individuals in the interviews that I undertook for the study. At the same time, the interview conversations guided my attention towards particular issues which I could later attend to in the process of participant observation. Shifting between these two 'data-collection' activities therefore provided me with multiple opportunities to consider the phenomenon of the reception meetings from different perspectives and to both refine and broaden my understanding.

'Sampling' strategy and details of participants

In a study which utilizes interviewing as a data-generation method, Flick (1998) comments that decisions regarding 'sampling' are raised in relation to who to interview (case sampling) and from which groups these should come (sampling groups of cases). Because the term 'sampling' is frequently associated with 'generalizability', however, the use of the concept within a study which embraces a social constructionist methodological position

requires clarification. Silverman (2000), for instance, states that sampling is generally considered to have two functions: ensuring 'representativeness' and also allowing the reader to make broader inferences. He cites Arber:

"The purpose of sampling is usually to study a representative subsection of a precisely defined population I order to make inferences about the whole population" (cited in Silverman 2000, p. 102).

Silverman comments that this view of 'sampling' is often not congruent with qualitative research, however, since extensive data are often derived from a small number of 'cases' which are unlikely to have been selected on a random basis. In addition, a postmodern emphasis on diversity, fragmentation and local knowledges serves to undermine ideas about the generalizability of 'findings' and the 'representativeness' of individual cases[1].

In this study, decisions about 'sampling' in relation to interviews were made on the basis of two broad factors:

1. Participants from the range of different social positions within the research site, (service-users, family members, professionals of different disciplines) were included to ensure that I engaged with multiple perspectives.

2. 'Convenience sampling' (Flick 1998), in which certain participants are selected because they were accessible under given conditions. This was an important consideration given the nature of the research site, where the situations of service-users could alter rapidly, and family members and professionals were often extremely busy and stressed and therefore their availability was limited.

The overall sample size was also delineated in relation to the above factors of inclusivity and convenience. A total of 27 people were interviewed for the study, 9 of whom were service-users, 7 were family members / significant others, and 11 professionals, (figure 3 provides brief information about the different participants). Two 'case studies', one featuring a service-user and the second a professional, are included in Appendix 3, part b, to

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[1] The issue of 'generalizability' in relation to postmodern research is returned to in Chapter 11 of the thesis.

provide a richer narrative picture regarding the kind of situations and dilemmas that participants in the study might typically be facing when attending the reception meetings.

Initially, I had also identified more specific criteria for the selection of participants, but over the course of the study these criteria became broader and more inclusive, as will be discussed in the section that follows.

The evolution of 'sample criteria' for the research interviews

When designing the study I initially developed a set of criteria to determine who I would invite to participate in the interviews, although I was aware that these criteria might require some revision over time according to the opportunities and constraints provided by the clinical setting. It was important that the research design and 'sampling strategy' were adapted to the conditions of the clinical setting, rather than visa versa. Pearce and Walters (1996) argue that the initial strategies that have been developed by researchers prior to entering the study site subsequently require 'defrosting' for application in specific, local contexts. This process of adapting or 'defrosting' the initial 'sample criteria' might be viewed as demonstrating a lack of rigour if considered from a positivist position where there is a concern with maintaining a fixed method in order to 'control variables'. Within qualitative research, however, rigour can be conceptualised differently as *"the principled development of strategy to suit the scenario being studied"* (Holliday 2002, p. 8). In line with the social constructionist ideas which informed the research methodology, my overall aim when inviting people to participate in the study was to engage with a multiplicity of voices. I was therefore concerned to hear the accounts of people occupying a spectrum of social positions in relation to the reception meetings, (service-users, family members, professionals) in order to thicken the descriptions of the phenomenon (Geertz 1993), rather than with objectivist notions of the 'representativeness' of the 'sample' as a means of uncovering a fixed social reality.

In relation to the evolution of an appropriate 'sampling strategy' for the study, the initial criteria that I developed stated that I would invite people to participate in the study who had attended reception meetings where:

- the service-user had entered psychiatric hospital for the first time
- the meeting was attended by at least one of the service-users relatives / friends
- the participants in the meeting have consented to the discussion being audio or video recorded

My initial decision to focus on people who were entering hospital for the first time was based on previous research undertaken by Whittle (1996), which proposed that first admission to psychiatric hospital has profound, and often negative effects on the individual's perceptions of themselves, and also how they are viewed by their significant others. Whittle concluded that the disempowering processes associated with hospital admission are maintained by problems of poor communication between staff and the service-user and family at the point of admission regarding the perceived nature of the problem. I therefore wondered whether the reception meetings might provide a forum for discussing these issues in a fruitful way, and hoped to learn more about this through the research.

Following discussions with colleagues who were involved in facilitating the reception meetings, however, I decided to expand the focus of the study to include interviews with service-users and their significant others who had experienced previous admissions. Several of my colleagues commented that the reception meetings were available to all service-users entering hospital, many of whom had experienced multiple previous admissions, and that it would therefore be useful to include their views in the research. One of the ethical principles guiding my research activity was an aspiration towards collaborative forms of inquiry, and so it seemed fitting to revise the criteria in response to these suggestions from colleagues.

Similarly, at an early stage in the process of 'data-collection' I chose to revise my initial intention to include in the study only those people who had consented to their reception meeting being video or audio-taped. Two people who I approached in this early period refused to allow their reception meeting to be recorded, but I gained the impression that they would have been happy to talk with me after the meeting about their experiences. It was in response to experiences of this sort in the early phase of the research that I decided that I would invite people to participate in the research regardless of whether the meetings had been recorded.

This alteration to the study design clearly held important consequences in terms of the type of data that was subsequently available for analysis, but was made in the interests of inclusivity. In addition, because the overall methodological orientation of the study led to a focus on voice and on participants' experiences of being able to speak and be heard in the reception meetings, it was congruent with this position that data-collection methods were used that allowed participants opportunities to speak for themselves. For this reason engaging in semi-structured interviews in which the research participants could comment on their experiences was a much higher priority for me as a researcher than having the opportunity to analyse segments of video from the meetings. I was aspiring as a practitioner researcher towards relationally engaged, conversational methods of inquiry rather than engaging in a more detached analysis of processes within the meetings.

The criteria that I initially developed for inviting people to participate in the interviews, as well as the range of data-collection methods that I had intended to employ therefore needed to be revised and developed in the light of experience as a researcher in the clinical setting. Otherwise, there was a danger that I would not gain access to the views of those people who might be experiencing the greatest sense of oppression as a consequence of their contact with psychiatric services, such as longer-term users who have experienced multiple admissions and who may have encountered consequent processes of stigma or prejudice within society, or people who were compulsorily detained in hospital and who might be less 'compliant' with staff requests to video-record meetings.

Following this period of refining or 'defrosting' the criteria that I had initially formulated, I developed the following very loose criteria which guided the process of inviting people to participate in research interviews:

- The meeting was attended by at least one of the service-users relatives / friends
- That I had been present at the reception meeting

Since I had moved away from the position that I would only invite people to participate in the interviews if their reception meeting had been recorded, it was crucial to focus on those meetings where I had been present to observe the meeting as it occurred, to ensure that the questions I asked in the subsequent research interviews were connected with events in the meetings.

Recruitment process for the interviews

When a person was admitted to the Unit the nurse who was attending to them would discuss the idea of arranging a reception meeting with the person and with any relatives that were present, and would provide a leaflet which explained the purpose of the meetings. The leaflet also stated that a research project was occurring, and that the researcher might invite them to assist by taking part in an interview. It was stated in the leaflet that they were free to decline this invitation and that this would not affect the service that they received (see Appendix 2). Following the reception meeting, I approached people personally to introduce myself and the research and to invite them to participate.

Staff working within the service were already aware of the research (as discussed earlier), so I approached them personally after reception meetings, asking if they would be willing to be interviewed. Further written information was provided in the form of a letter which briefly stated the overall aims of the research, and which explained that if they agreed to be interviewed I would prefer to audio-tape the discussion for the purpose of transcription at a later date. Assurances about confidentiality were also provided in the letter, and it was stressed that the person was free to decline the request (see Appendix 2). I also reiterated these points verbally with staff.

The research interviews took place at a time that was convenient to participants, and usually occurred on the Unit. Where possible, a choice of venue was offered, since I was concerned that some participants might prefer a more 'neutral' setting. Three of the service-users who were interviewed were detained in hospital under Mental Health Act (1983) legislation at the time that the interviews occurred, however, and were unable to leave the Unit. In these instances, a choice of venue was therefore not an option. Goodwin et al. (1999) have suggested that psychiatric service-users might be constrained from expressing their opinions when research interviews occur in hospital settings because of the marked imbalance of power between professionals and service-users in these environments. In this study, however, convenience seemed to be the principle factor governing the decision about where to meet, with the majority of participants electing to meet on the Unit when a choice was offered. A quiet room was available where the conversations could occur free from interruptions.

Ethical issues in the interview process

One of the ethical dilemmas that was encountered during the course of the study pertains to interviewing hospitalised service-users who were in a fragile psychological state. An issue was raised regarding the capacity of these participants to provide informed consent, since this requires an ability to fully understand what one is agreeing to. In addition, the question of how free individuals in this social setting might have felt to decline the invitation to take part in the study also required consideration. Service-users might well feel coerced to take part in research when invited to do so by a member of the clinical team who is responsible for their present and future treatment, despite having been provided with verbal and written assurances that they were free to decline. Similarly, previous research has identified high levels of stress and psychological problems amongst the relatives of people with severe psychiatric disorders (Shepherd, Murray & Muijen 1994) and so ethical dilemmas are raised regarding the appropriateness of asking people to participate in a research programme at a time when they may be feeling vulnerable and under stress. There is also a danger that relatives might have felt obligated to be 'helpful' by taking part in the study, in case they compromised the service-users treatment through lack of co-operation. In considering the degree to which people may have felt coerced into participating in the study, it is important to reiterate that everyone who was invited to take part in interviews received verbal and written assurances that they were entirely free to decline, and that this would not prejudice the services that were offered. It is also important to emphasize that while most people who were approached did agree, some did refuse the invitation to take part.

Regarding the issue raised earlier concerning the extent to which it is exploitative to include people in the interview process who were in unusual states of mind, I tried to hold this question in mind throughout the data-collection phase of the study. One of the strategies I used to assist me in attending to this was to routinely seek the views of ward staff prior to approaching individual service-users to discuss the appropriateness of interviewing them. On a couple of occasions members of the nursing team responded to my enquiry by suggesting that it would not be appropriate to approach a particular service-user at that time because they were in a particularly distressed or fragile state. In response to this advice I would either defer approaching the person concerned or decide not to include them in the study, according to specific circumstances. I also used my own clinical experience as a

guide in judging whether to proceed with the interviews at times when I felt that the service-user was not 'well' enough to proceed with the discussion.

Despite the complex ethical issues that needed to be considered, I felt that it was important that the research included the voices of service-users who were considered to be in the midst of severe psychiatric disorder and those who were detained in the Unit, since these are increasingly the majority populations within adult acute admissions units in the UK (Dept. of Health 1999a). Failure to include the views of those who were in this situation would therefore have undermined the relevance of the study. It would also have been contradictory to exclude these participants, since one of the principles of the reception meetings was that people who are in unusual or 'psychotic' mental states can benefit from participation in network meetings and can contribute meaningfully and usefully, a view supported by the Finnish research in this field (Holma & Aaltonen 1995).

A further factor that I held in mind when considering whether to invite individual service-users to take part in the study was the tendency within Western culture to underestimate the abilities of those who are defined as 'mentally ill'. Swartz (1992) argues that there is a tendency amongst researchers to underestimate the contributions of people with a psychiatric diagnosis, and to regard what is said as less coherent than it is. In the research I was therefore careful to try to maintain a balance between avoiding placing additional pressure on distressed individuals by asking them to take part in a research project when it was inappropriate to do so, while at the same time wishing to avoid slipping into professional dismissiveness or paternalism.

RESEARCH PARTICIPANTS

Service-users

Name	Brief contextual details	Type of interview
Vicky	*White woman in late 30's, married with children. Admitted voluntarily. Two previous admissions.*	*Individual interview (Audio-taped)*
Christine	*White woman in early 20's, married with baby. First admission to hospital. Detained under the Mental Health Act.*	*Individual interview (Audio-taped)*
Adam	*White man in early 40's with partner, no children. Parents also present at reception meeting. Admitted on a voluntary basis. Episodic contact with psychiatric services since mid-teens, with several previous hospitalisations*	*Family interview (Adam & parents, Dave & June). (Audio-taped)*
Frank	*White man in late 40's with wife and two teenage children. Admitted voluntarily. First admission.*	*Couple interview (Written notes)*
Maria	*White woman in late 50's, admitted voluntarily. Recently separated from violent male partner. Two adult children. No previous admissions.*	*Individual interview (Audio-taped)*
Marion	*White woman in early 50's, living with male partner. Long history of contact with mental health services, including previous hospitalisations. Admitted voluntarily.*	*Individual interview (Audio-taped)*
Imogen	*White woman in early 40's with male partner. Admitted under the Mental Health Act. Long history of previous contact with mental health services.*	*Individual interview (Written notes)*
Howard	*White single man in mid 40's, with no children. Lives with mother (not interviewed). Detained under the Mental Health Act. Several previous admissions to hospital.*	*Individual interview (Audio-taped)*
Peter	*White single man in late 20's, living with mother. Detained under Mental Health Act. Several previous admissions to psychiatric hospital.*	*Individual interview (Audio-taped)*

Figure 3: Overview of research participants

Family members / significant others

Jim	*White man in late 30's, husband of Vicky*	*Individual interview (Audio-taped)*
June	*White, mid 50's woman, mother of Adam (service-user). Married to Dave (also present at interview)*	*Family interview (husband Dave and son Adam present) (Audio-taped)*
Dave	*White, mid-50's man, father of Adam (service-user). Married to June (also present at interview)*	*Family interview (wife June and son Adam present) (Audio-taped)*
Caroline	*White single woman in late 20's, daughter of Maria*	*Individual interview (Audio-taped)*
Melanie	*White woman in mid 40's, wife of Frank*	*Couple interview (Audio-taped)*
Brenda	*White married woman in early 50's, mother of Nick (service-user, who was present at interview but did not participate verbally)*	*Family interview: Nick present but declined to comment (Audio-taped)*
Mrs. Conrad	*White married woman in late 50's, mother of Derek.*	*Individual interview (Audio-taped)*

Figure 3 (continued): Overview of research participants

Professionals

Helen	CPN to Vicky. White Irish woman in late 20's. Also trained in counselling.	Individual interview (Audio-taped)
Bernadette	Member of in-patient nursing team, and primary nurse to Vicky. Also member of reception meeting team. White woman in late 20's.	Individual interview (Audio-taped)
Karen	Student nurse to Christine. White woman in early 20's.	Individual interview (Audio-taped)
John	Consultant psychiatrist to Christine. White man in early 50's. Also trained as family therapist, and was a member of the reception meeting team.	Individual interview (Audio-taped)
Carl	CPN to Imogen and member of reception meeting team. White man in late 20's.	Individual interview (Audio-taped)
Jane	Social worker to Marion. White woman in early 30's.	Individual interview (Audio-taped)
Max	Member of in-patient nursing team, and primary nurse to Nick. White man in late 20's.	Individual interview (Written notes)
Colin	CPN to Nick. Colin had also recently worked in in-patient Unit. White man in early 50's.	Individual interview (Audio-taped)
Okeke	CPN attached to community team working with Nick (service-user). Also trained in family therapy. Black Ghanaian man.	Individual interview (Written notes)
Susan	Support worker to Marion (service-user) and member of in-patient nursing team. Also member of reception meeting team, and active in voluntary organization for relatives of people with psychiatric disorder. White woman in mid 40's.	Telephone interview (Written notes)
Holly	Member of hospital nursing team, Primary nurse for Fatihma (service-user, not interviewed) White woman in early 50's.	Individual interview (Audio-taped)

Figure 3 (continued): Overview of research participants

Interview method

Writing from a social constructionist position, Sandelowski (1991) argues that research interviews need to be rescued from attempts to standardize and scientize them, so that they can be reclaimed as occasions for the sharing of stories. Since human lives are shaped by narrative, Sandelowski contends that narrative methods of research parallel the forms of inquiry that people engage in on an everyday basis. From this perspective, all participants in the research process, (including the researcher, the interviewees and the readers of the research report), are narrators who are located within a hermeneutic circle of interpretation. In the interviews undertaken for this study I attempted to maintain a relaxed, conversational approach in the hope that they might become 'occasions for the sharing of stories' about the reception meetings.

The majority of the interviews were with individuals, but this varied according to the preference and convenience of those concerned. One of the interviews was conducted with a service-user and his parents for instance, while another was with a man who had been admitted together with his wife. As a systemic practitioner, I had no objection to interviewing more than one person if that was their preference. At the beginning of the interviews I briefly stated that I was interested in learning about people's experiences of the reception meetings, and explaining that the research will inform the practice of staff working in this field.

A loosely-structured format was adopted for the interviews, to maintain a conversational flow with participants. I approached each of the interviews with a number of key themes in mind that I was interested in exploring. These themes related to:

- Any initial expectations that participants described regarding the reception meetings, and how these initial expectations influenced their subsequent stories about what occurred in the meetings.

- The participants stories about being in the reception meeting, and the perceived value or helpfulness of the discussion that occurred.

- Issues of voice within the meeting, including the extent to which participants felt able to express their point of view, and whether they felt what they had said was heard by the others who were present.

- The perceived impact of the reception meeting on individual participants' relationships with others who took part in them, for instance, relationships between service-users, family members and staff.

- Which contributions from the staff hosting the meeting were felt to be helpful or unhelpful.

The interviews were usually approximately an hour long, with occasional exceptions where the conversations were either quite brief or very lengthy. There were a number of factors associated with the fraught environment of a psychiatric admissions unit that occasionally limited the time available: low staffing levels sometimes meant that nurses who were interviewed could only be away from the busyness of the ward for limited periods, the potentially fragile state of mind of some service-users required sensitivity regarding timing, and family members occasionally had limited time available because of their busy schedules. Despite these constraints, participants also often seemed keen to discuss their experiences. Opportunities to sit and talk in a reflective manner can be rare in admissions units (Johnstone 2002), and I think several of those who took part valued being invited to do so.

Transcription

The majority of the interviews undertaken for the research were audio-recorded for the purpose of transcription at a later date. Exceptions to this occurred when the participant didn't give consent for recording to occur (one person); on another occasion an interview took place over the telephone because the person concerned would not otherwise be available for several weeks; there was also a few instances where the technology let me down and I thought a recording had been made but subsequently discovered that this was not the case. In those instances where a recording hadn't occurred, written notes were made immediately following the interviews.

The transcription of interviews entails a process of (re)structuring the material in a way that allows for closer analysis (Kvale 1996). There are a number of different approaches to transcribing interviews within the qualitative research field, from the very detailed technical procedures used in discourse analysis where patterns of speech such as turn-taking, moments of overlapping talk or brief pauses are carefully noted, to more holistic approaches where there is an emphasis on attending to the overall narrative sense of what is being said rather than the detail of individual speech acts. Kvale (1996) argues that there is no single 'correct' method of transcribing which ensures reliability since to *transcribe* is inevitably to *transform* from one narrative mode to another, each with different rules and conventions. Also, from a postmodern perspective there is no one true meaning attached to an interview which can be 'captured' through careful methods of transcription. Instead, Kvale argues that the method used should depend upon what the researcher intends to use the transcriptions for. In this study, I was less interested in undertaking the kind of micro-analysis of segments of text associated with discourse analysis approaches, but rather, I intended to focus upon issues of voice and story which might best be viewed by standing back slightly from the minutia of the text in order to attend to the different stories told, metaphors used, and so on, which are situated in an organic, co-evolving conversational process.

In the process of transcribing the interviews, I observed the following guidelines: while accepting that variation will inevitably occur in the translation from the spoken to the written word, I nevertheless attempted to (re)produce the words that were spoken in the interview as faithfully as possible in that I transcribed the interviews in their entirety, without editing out passages, sentences or particular words used. It was tempting to do so at times, however, as the conventions of speech tend to be more flexible than the conventions for writing, and so episodes of speech which sounded coherent on tape occasionally appeared vague, repetitive or rambling when reproduced on the page. Where comments were inaudible on the tape, this is indicated in brackets. Similarly, when a comment was accompanied by laughter or other non-linguistic expressions of strong feeling, this is also indicated in brackets since the emotional tone with which a particular statement is made can significantly alter its meaning. I have also indicated in brackets any points in the conversation where lengthy pauses in a person's speech occurred. When a person's speech appeared to tail off before a sentence was completed, I have indicated this using a series of dots, as in the following example from an interview with Adam, a service-user who participated in the study:

Adam: Yes. I was going through a lot. I was just going through a lot which was a subjective experience was very, very painful. But because I thought I was... I felt I had to get things out fairly quickly.

Occasionally, I have added brief points of clarification in brackets, in instances where the speakers meaning seemed clear in the conversational context, but might get lost when transposed to transcript. In the following extract from an interview with one of the nurses in the research site, for example, I have added the phrase "other than medication" in brackets since the context for this comment was a discussion about the degree to which medical staff tend to focus on drug treatment when they are present at meetings: *"I'm not sure how involved doctors would want to be in the rest of the things (other than medication) that get discussed at reception meetings".* The addition of these brief clarifying comments was therefore intended to clarify the meaning of what was being said, (as I interpreted it), rather than to alter the speaker's account.

Summary

This chapter discussed issues of 'access', 'sampling' and 'recruitment', as well as the range of data-collection methods which were employed in the research. These methods were congruent with the postmodern methodology and the practitioner research design of the study, in that they allowed engagement with multiple perspectives regarding the reception meetings and the organizational context of the research site. The process of transcribing the interviews from spoken to written text has also been discussed, along with some of the methodological and ethical dilemmas associated with this activity.

In chapter 6 the interpretive methods that I employed in the research will be discussed. Again, care was taken to select and adapt methods for use which were congruent with the postmodern methodology of the research, and which supported a focus on issues of voice and perspective.

Chapter 6. Interpretive procedures

In this chapter the interpretative procedures that I employed as a framework for analyzing the data for the study are discussed. As a precursor to this, however, in the interests of 'transparency' I will position myself in relation to the analytic process by provide a brief autobiographical sketch. This will provide the reader with a picture of my personal and professional background as a practitioner researcher, and how these contexts have shaped my interaction with the data.

Autobiographical context: positioning myself in the process

Steier (1991) suggests that research is, in a sense, an autobiographical endeavour. This is not to say that it is a process of endless (and therefore pointless) solipsism, since knowledge creation is essentially a social process. Our understandings of any situation are, however, always situated, partial, and coloured by our past as well as current contexts (Warnke 1987). According to the German philosopher Hans Georg Gadamer, any act of interpretation occurs against a "horizon of understanding", a network of prejudgements or preunderstandings, that inform the questions that we ask and our responses to the answers that we receive (cited in Gergen 1999, p. 144). These preunderstandings, or 'prejudices' as Gadamer referred to them, do not dominate our experiences of the world in such a way that we are closed to new ideas or experiences, but rather :

"Prejudices are biases or our openness to the world. They are simply conditions whereby we experience something-whereby what we experience says something to us. This formulation certainly does not mean that we are enclosed within a wall of prejudices and only let through the narrow portals those things that can produce a pass saying, "Nothing new will be said here". Instead, we welcome just that guest who promises something new to our curiosity". (Gadamer, cited in Cecchin et al. 1994, p. 8).

The prejudices of the researcher can never be eliminated or 'bracketed' from the interpretive process. Rather than undermining the research, these prejudices and values make it meaningful (Koch & Harrington 1998). Reflexive recognition of our own prejudices is

therefore extremely valuable in allowing us to understand what we bring to the act of interpretation. Similarly, transparency within the research text regarding the positioning of our personal 'selves', our history, values, assumptions and biases, allows the reader to see something of how we, as researchers, have participated in making and interpreting the data which is presented. In reflexive spirit, it is therefore appropriate prior to discussing the interpretive procedures I utilized to share something of my own personal and professional 'self' with the reader, and discuss the prejudices and values that I have developed over time through my work in the mental health field.

My background as a practitioner

My late teens and early twenties were a period of cheerfully drifting through life, and in the late seventies I seemed to fall into, rather than actively choose, a job as a nursing auxiliary in a large Victorian built mental hospital, just outside of Newcastle upon Tyne. I had no intention of holding this job for any length of time, just long enough to earn a bit of money would do me fine. Despite these intentions and the general grimness of the institutional surroundings, something about the work appealed to me, and after a few weeks I decided to train to become a registered nurse (R.M.N.). It's hard to say exactly what this attraction was, but with the benefit of hindsight, I suppose it was rather an obvious career choice for me. I had grown up in a small town where a large hospital for people with learning difficulties was located, and several members of my immediate family as well as a number of my close friends worked there. Because of this there was something very familiar for me about this strange institutional setting I had found myself working in. As a young person with leftward leanings I also liked the idea of work which was intended to be helpful to people, rather than profit orientated. The contradictions between the notion of a 'caring' hospital where people went to be looked after and the grimly oppressive psychological and physical environment that I encountered didn't escape me, however. Before entering nursing, I had read the standard texts for 'alternative' counter-culture types in the early to mid-seventies, the 'anti-psychiatry' stuff- Ronnie Laing, David Cooper, Ken Kesey- and for the rebellious part of me that was interested in the idea of helping to 'change the system', here was a system in dire need of changing!

Three years later I emerged with a nursing qualification and an interest in psychotherapeutic theories, but precious few opportunities to see this kind of work in action in the hospital I was working in. The task of sticking around to try and help improve the local service now that I had a qualification no longer appealed to me very much. I'd had enough, and decided to move to London, spending the next few years of my working life working in therapeutic communities. First developed in the forties by inspirational characters like Maxwell Jones, therapeutic communities are units organized around permissive and democratic principles, where the residents and staff engage together in a process of examining their day to day interactions with one another with the aim of learning new patterns of relating to people and the world (Whiteley, Briggs & Turner 1972). During this period I also undertook some group therapy training and some personal psychoanalysis, and my immersion in this field strengthened my belief that psychological problems can be addressed if people are given the opportunity to talk about and explore the concerns in their lives with others in a safe enough setting.

In the early eighties I returned to the North East, where my partner Jan was living. Colleagues in Newcastle who had done some family therapy training introduced me to this way of working, and I fairly quickly found myself hooked. Through my therapeutic community experiences I was already attracted to group-based approaches, as I liked the energy and creativity that is created when several people come together to solve a problem. Family therapy was also optimistic, change focused and irreverent towards psychiatric orthodoxy. As a close colleague jokingly commented, in the seventies and eighties the family therapy scene seemed to be a *"rallying call for troublemakers"* and as such, it was guaranteed to appeal to me!. On top of all this, it seemed to 'work', sometimes creating changes for people who had been stuck in their lives for long periods.

Any telling of a history is inevitably partial and selective, of course, but looking back it's easy for me to see how these professional experiences contributed to the development of particular assumptions and prejudices that were central to my interest in the reception meetings, and to the manner in which I have engaged in this research. My interest in, and belief in the value of group and relationally-orientated approaches to practice was formed fairly early on through my therapeutic community experiences, as was my view that traditionally organized institutions, and that hierarchies between professional groups and between professionals and service-users were not only distancing, but also damaging. As a

researcher, these experiences and prejudices also shaped the ways in which I heard and read the 'data', by influencing both what I hoped to hear from participants and also where the surprises were in the stories I listened to.

Data-analysis in practitioner research

Reed and Procter (1995) discuss particular dilemmas which surround the process of data-analysis within practitioner research, relating to the researchers familiarity with the research setting. The prior knowledge of the practitioner researcher may result in a lack of curiosity and the imposition of particular categories of analysis or interpretation upon the data. The position of the practitioner researcher within the research process therefore makes it difficult to argue that a purely inductive approach to data-analysis can be used. The potential for the researcher to impose his or her interpretations and for alternative meanings which were carried in the voices of participants to be suppressed is therefore one which needs to be addressed within a practitioner research design. This tension is also present in feminist and emancipatory research approaches, which also favour a more engaged researcher position (Reed & Procter 1995).

It was therefore the process of analyzing the data that initially created the greatest sense of uncertainty for me as I struggled to find or develop a method that was congruent with the postmodern methodology and the practitioner research design of the study. The term 'method' in itself seemed problematic, suggesting a modernist emphasis on 'correct' analytic procedure which was incongruent with my search for a way of engaging with the data which would maintain the relational, conversational dimension of the research. Discussing social constructionist research, Burr (1995) distinguishes between **'discourse analysis'** approaches which tend to follow very precise procedural guidelines and **'the analysis of discourses'**, which she describes as a more intuitive, deconstructive approaches akin to the reading of literary texts. In scrutinising the qualitative research literature for inspiration, I was looking out for examples of the latter approach which were both flexible and at the same time sufficiently detailed that they would offer practical suggestions about how I might approach the data.

The research approach of feminist psychologists Brown and Gilligan (1992) was particularly useful in this respect, since it describes the micro-processes of data-analysis but also retains a focus on the relational context of the research and the data which are being interpreted. Reading the work of Brown and Gilligan, I identified several areas of overlap with the key concerns of this study, particularly their focus on voice and relationships. Brown and Gilligan comment:

"We wished to create a way of working that sustained other people's voices and our own- to voice the relationship that was at the heart of our psychological work. We were looking for a way to capture the layered nature of psychological experience and also the relational logic of psychological processes". (Brown & Gilligan 1992, p. 11).

Because of the relational dimension of this approach, it seemed generally well suited to the requirements of this study and I therefore decided to adapt it for use in this context.

The voice-centred relational method

Brown and Gilligan (1992) developed this approach in the course of a study which explored the psychological development of teenage girls. Over time they became increasingly aware that the structured interview formats, psychological procedures, and so on, that they were using in the earlier stages of their study discouraged the girls from speaking freely about intimate thoughts and feelings. Brown and Gilligan came to realise that if they were to establish a connection with the girls and develop an understanding of the issues that they struggled with in their lives, they would need to move towards a more responsive research approach; that is, a relational method was required which didn't suppress either the voices of the girls, or the voices of the researchers themselves. They therefore developed what they describe as a 'listener's guide' for their research, an approach which sought to appreciate and explore the complexity of the girl's psychological and social worlds, rather than to reduce or standardize what they had to say. Brown and Gilligan (1992) suggest that this relational research approach entails the researcher engaging in a process of attending both to the words of the research participants, and also to the relational dimensions of their own listening, speaking, interpreting and writing about the stories of others.

Discussing the work of Brown and Gilligan, Mauthner and Doucet (1998) suggest that this 'voice-centred relational method' holds at its centre the postmodern idea of a relational self. The idea of the single, unified self, located within the individual which is dominant within Western cultures is undermined within postmodern and social constructionist writings by an alternative account of the self which is relational and multi-voiced in nature (Hermans 1999; Holquist 1990). We are always 'selves in relation' or 'selves in dialogue' (Watkins 1999). From a social constructionist perspective, our private thoughts and 'inner' selves are dialogically structured, comprising a multiplicity of internal voices which endlessly interact with one another. As with our 'external' worlds, our 'inner' worlds are also therefore essentially social.

The "listener's guide" is also a political strategy as well as a relational research method, according to Brown and Gilligan (1992). It is political in that it is concerned with the dominance of male power within society and the impact of this system of power on the lives of girls and women: it is concerned with the suppression of female voices. The approach therefore seems well suited for use within the mental health field where the present study is located, since psychiatry is a site where there are frequently multiple and contested constructions of reality in play.

The concept of 'voice'

Some commentators have also raised concerns about the notion of 'voice', as it has been developed in the work of Brown and Gilligan (Davis 1994; Kitzinger 1994). Davis (1994), for instance, argues that the term 'voice' was initially used metaphorically by Gilligan in her early writings in order to draw attention to male bias in the academic world and in scientific research, but in her later work, the term is used in a literal sense. Gilligan herself has confirmed that she is speaking literally when referring to 'voice':

"... 'voice' means 'voice' to me. I listen as I read. My training in literature was very close to textual analysis and I picked up what you're not supposed to pick up in psychology- that there was a voice, and I asked 'Who's speaking?'; 'Whose voice is this?'; 'Whose body and where's it coming from?'. If you listen to the imagery of sexuality and separation and everything else, you realize this is a man's body. This is a man's voice speaking as if from

*nowhere. Then people kept talking about the **metaphor** of voice, and the **concept** of voice, and the **instrument** of voice. ...And I came back to my work thinking, next time somebody says to me 'the metaphor of voice' or ' the concept of voice', I will say, 'No; by "voice" I mean "voice"*. (Gilligan, interviewed by Kitzinger 1994, p. 413).

For Gilligan, the research method that she developed with Brown enabled them to listen to the 'authentic' voices of the girls in their study, the times when they are speaking with their own 'true voices', rather than saying what is expected of them, speaking with the voices of others. Kitzinger (1994) challenges this notion of a true, core self from which one speaks, a 'real me' which exists prior to, and is oppressed or covered up be the social world. Instead, for Kitzinger, the 'self' is multiple, and ongoingly constructed through social interaction.

In this research I am employing the term 'voice' in the postmodern, pluralist manner proposed by Kitzinger. Our 'selves' are composed of multiple interacting voices, some of which speak and are heard more clearly in particular contexts where others are silenced. The theoretical tensions between this concept of 'voice' and the essentialist account proposed by Gilligan does not undermine the usefulness of the voice-centred relational method in this study, however, but simply means that the 'voices' that are engaged with are conceived of differently: as a researcher I am interested in 'hearing' the multiple voices of individual participants, rather than attempting to identify the moments when they speak with their 'true voice'.

Steps involved in the method

The voice-centred relational method broadly entails two stages; the first stage consisting of multiple readings of the individual interview transcripts, followed by a second stage of considering the data-set as a whole and identifying connecting themes, (see figure 4 for a summary).

This procedure, as developed by Brown and Gilligan (1992), focuses specifically on data generated through interviews. Silverman (1998), however, is critical regarding what he considers to be the over-reliance on unstructured interviews within qualitative research at

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the expense of other methods which provide different forms of information. In addition, Davis (1994) argues that the work of Brown and Gilligan does not sufficiently attend to "ethnographic detail", to the specifics of the contexts in which the interviews occurred. Because of my own position as a practitioner / researcher, within this study I had the opportunity to access data from multiple sources which might serve to enrich the overall picture created through the study. In adapting the voice-centred relational method for the purposes of this research, I therefore initially focused on the individual interview transcripts in the first stage of the analytic process, in the manner suggested by Brown and Gilligan, but in the second stage I looked across the data-set as a whole, including material from the different sources available to me, to generate broader connecting themes and to gain different perspectives on the material gained from the interviews. Data gained from the participant observer activity, for instance, as well as secondary sources such as correspondence about the reception meetings, were extremely useful in adding this "ethnographic detail" regarding the organizational context of the research site, a context which inevitably shaped participants experiences in and stories about the reception meetings.

Stage 1: Multiple readings of the interview texts from different positions	Stage 2: Developing connections and themes from across the data-set
• Reading for the different stories told • Reading for the researchers responses to the narratives • Reading for the voice of the 'I' • Reading for relationships • Locating people within wider social & cultural contexts Reading for the influence of the research relationship on the stories told	This stage involves moving from interpreting the interviews with individual participants to generating an holistic understanding of the data-set as a whole, including data from other sources. Broader themes and connections are created from within and across the data-set.

Figure 4: Voice-centred relational method of data-analysis

(adapted from Brown & Gilligan 1992)

Stage 1: Multiple readings

This stage entails a series of readings of the interview transcripts, with the researcher attending to different aspects or layers of the narrative on each occasion. It is important to stress, however, that this procedure differs in theoretical orientation and aims from the technique of 'investigator triangulation' which is often used in qualitative research, whereby different observers or observer strategies are employed to identify and remove researcher bias (Flick 1998). The term 'triangulation', as it is commonly employed, suggests a positivist bias, as is highlighted in the following definition offered by Silverman (2000, p. 301), *"the attempt to get a 'true' fix on a situation by combining different ways of looking at it or different findings"*. The positivist notion that engaging in multiple readings of the data might allow the researcher to arrive at a 'truer' interpretation of events is counter to the polyphonic ethos of the voice-centred relational method. Brown and Gilligan (1992, p.25) propose that through engaging in multiple readings, *"we begin to sort out different voices that run through the narrative and compose a polyphonic or orchestral rendering of its psychology and its politics"*.

Within this study, I engaged in a process of reading the individual transcripts several times from the following different 'reader positions':

Reading 1: Reading for the different stories told

This first reading entails focusing upon the different stories told in the interview. The individual transcripts were read for the stories told by the person being interviewed. In this first reading I tried to particularly notice and be responsive to "arresting moments" in the text, moments when the language used and the images or metaphors employed by participants seem to be arresting, striking or poetic in some way. Katz & Shotter (1996) propose that by allowing ourselves to become responsive to such moments in the words or actions of another we can more readily develop an understanding of the person's unique world.

Reading 2: Researcher responses

In the second, 'researcher response' reading the researcher, *"reads for herself in the text in the sense that she places herself, with her own particular background, history and experiences, in relation to the person she has interviewed"* (Mauthner and Doucet 1998, p. 126). This entails the researcher listening for their own relationship to the speaker or the text, and attempting to identify how their own biases and limitations might influence the process of interpretation. Mauthner and Doucet recommend that the researcher traces his or her own feelings in relation to what s/he hears, particularly those feelings which do not resonate with what the speaker is saying. This process allows the researcher to reflexively revisit and examine how and where their own assumptions and views might affect the interpretation of the speaker's words, or how s/he subsequently writes about the person.

This second 'reading position' was helpful in assisting me to be self-reflexive in the process of reading the transcripts, allowing me to notice, for instance, occasions where there was tensions between what a particular participant said about the reception meetings and my own beliefs as a practitioner researcher.

Reading 3: 'I' –positions in the participants stories

This reading entails attending to moments in the interview when the research participant is speaking from an 'I' position. The researcher focuses on how the participants speaks about themselves; what stories they tell about how they experience and feel about themselves. In this study, reading for these 'I' positions in the interview texts was helpful in drawing my attention as a researcher to the participants unique experiences and emotional responses within the reception meetings. Focusing upon this dimension provided, for instance, suggestions regarding the extent to which participants felt 'safe' enough emotionally to contribute to the discussions that occurred in the meetings they attended, and whether they felt listened to and respected in these settings.

Reading 4: Relationships

This fourth reading entailed noticing how the participants speak about their interpersonal relationships, for instance, with partners, friends, relatives, professionals, and the wider social networks in which they live. In this study I interviewed service-users, family members and staff who had participated in reception meetings. As well as reading the interview transcripts to find out what stories participants told about themselves and their own experiences of the reception meetings, I therefore also attended to the stories each person told about the others who were involved in the meetings.

Reading 5: Social context

This reading focuses on how individuals experience and are influenced by the particular social context(s) from which they are speaking. The dominant social discourses about mental illness, for instance, can influence the lives and relationships of people positioned as 'service-users' and 'relatives' or 'carers' in profoundly disempowering ways (Reed 1999). Similarly, psychiatric staff may find the repertoire of stories they can tell about themselves and their work restricted by dominant stereotypes regarding how a 'doctor', 'nurse', 'social worker' and so on, should act. These stereotypical narratives might also shape expectations of how others should behave, and of what kind of discussions were appropriate within the reception meetings.

One of the aims of the reception meetings was to create a forum in which dialogue could occur; that is, in which a polyphony of voices might be heard including the more personal voices of the people who were present, rather than participants speaking and interacting through narrow and impoverished stereotypical roles and institutional habits of talk. This reading, which focused on the ways that participants spoke about their social positions, and how they experienced these in the context of the reception meetings, was therefore helpful in thinking about the extent to which this aim was achieved.

Reading 6: The research relationship

Brown and Gilligan's research approach has received criticism from a number of commentators on the basis that it does not pay sufficient attention to the socially constructed nature of research accounts (Davis 1994; Gremmen 1994; Kitzinger 1994; Lykes 1994). From my own perspective as a practitioner researcher who had a dual relationship with the people I interviewed, this critique of the voice-centred relational method was of central significance. Failure to consider the impact of the research relationship on the stories told within the interviews would, it seemed to me, undermine the credibility of the study. My own reading of Brown and Gilligan's work suggested to me that their method incorporates a degree of reflexivity by attending to the researcher's responses to the stories told by participants. The multiple readings that they suggest the researcher undertakes includes a focus on how the researcher is responding to the material in the transcripts, as discussed above.

At the same time, it seemed to me that Davis (1994) is accurate in arguing that the Brown and Gilligan's method does not sufficiently consider the specific situational context of the interview, and how the research relationship shapes the stories that are told. I therefore modified Brown and Gilligan's method for use in this research by including a further, sixth reading in which I specifically focused on the relationship between the research participant and myself in the interview. One issue that reading the transcripts from this perspective highlighted for me was that the research participants frequently seem to relate to me differently across the course of the interviews. At times individual participants seemed to relate to me primarily as a 'researcher', and at other times as a 'practitioner' within the interview. Taking account of this shifting definition of the relationship allowed me to consider how this factor might subtly nuance the conversational process within the interviews. The ways in which the research relationship provided a significant context in shaping the stories that were told by participants regarding the reception meetings will be considered in chapter 13 of this thesis, in which the opportunities and constraints associated with the research methodology and methods are re-viewed.

A full interview transcript is presented in appendix 3, part a, which includes the annotations I made during the process of multiple readings. This is provided to give the reader a picture of the multi-layered nature of the interpretive process.

In the section that follows, the second stage of the voice-centred relational method will be discussed. While the first stage requires the researcher to focus intensively on specific interview transcripts, this second stage entails a process of engaging with the data-set as a whole in order to create connections and develop broader themes.

Stage 2: Considering the data-set as a whole

Because of the different foci associated with each of the multiple readings within the first stage of this method, the interview transcripts were considered from a range of perspectives. The second stage entailed a process of generating themes from across the data-set. Data from a range of sources were therefore included in the interpretive process at this stage. These sources included not only the research interviews, but in addition, material generated through participant observation such as audio-recordings of staff meetings and discussions with individual members of staff, my research journal, and also data from 'secondary sources' such as correspondence and clinical notes, (please refer to the previous chapter for a discussion of the data-collection methods).

During the first stage of the process of data-analysis I attempted to engage in the process of multiple readings of the transcripts 'naively', in that I avoided holding specific question or themes associated with the overall research aims in mind. As a practitioner researcher who had strong prior beliefs of my own about the reception meetings and about the research site, it was particularly important for me to initially put these beliefs to one side and adopt what is known in the systemic practice field as a 'not-knowing position' in relation to the data (Anderson 1997). While it is, of course, impossible 'not to know' in the sense of not having prior ideas, hypotheses, prejudices and so on, the voice-centered relational method with its emphasis on multiple readings from different perspectives is a useful tonic for over-rigid beliefs.

In the second phase of the data-analysis process which entailed generating broader connecting themes from across the data-set, I also initially adopted a 'not knowing' position, akin to that recommended within grounded theory where themes and codes are developed inductively from the data (Strauss & Corbin 1994). In this process I attempted to

temporarily set aside a priori questions associated with the overall research aims so that the potential for 'surprising results' was enhanced. While the use of an inductive approach is valuable in minimizing the extent to which the researcher's ideas are imposed upon the data, a potential disadvantage is that the process of analysis can become directionless and the volume of themes that are generated can proliferate to the point of becoming overwhelming (Miles & Huberman 1994). Having initially adopted this inductive approach I therefore subsequently returned to the a priori research questions which related to issues such as the research participants experiences of voice in the reception meetings and the extent to which opportunities for dialogue appeared to have been created in the reception meetings.

Returning to a priori questions during this later phase provided a structure which helped me to shape and order the mass of themes that I had generated thus far. Alvesson and Skoldberg (2000) argue that there is no radical conflict associated with a researcher moving between a 'blank' or 'not knowing' strategy towards data-analysis and approaching the data in a manner which is more deliberately focused upon particular questions or theoretical themes. Instead, these authors contend that combining these strategies can enhance creativity in the interpretive process by avoiding the pitfalls associated with an over-allegiance with either position. In addition, the different interpretations of the data which are developed through employing these different strategies allows for multiple 'insights', undermining any tendency towards adopting a naïve realist position in which one particular interpretation is considered 'self-evident'.

Revisiting the overall research aims at this phase of the study required me to re-immerse myself in the data with a series of associated questions in mind that were a priori to the data collection process:

- How did the kind of talk that it was possible for participants to engage in within the reception meetings relate to the organizational culture of the research site?
- What stories did participants tell about their experience of voice in the reception meetings? Did the participants feel able to speak and be heard in the meetings?
- What, if any, stories did participants tell about their relationships with others in the reception meetings, and in what ways participation in the meetings influenced their subsequent relationships with these others?
- What were the practice implications of the stories told through the research?

While it would have been possible to develop a structure and headings for presenting the data which was explicitly linked with the six different reading positions associated with the first stage of the voice-centred method, I instead approached these multiple readings as opportunities to engage in a more unstructured, exploratory process of engagement with the interview texts. Returning in the second phase of data-analysis to these a priori questions then provided a general framework for creating connections between the wealth of themes that were generated during the initial phase. Without this general framework, the volume and range of themes would have been practically unmanageable and narrative coherence would have been absent. These broader themes provided the range of headings under which the data is presented in subsequent chapters of the thesis.

Summary and overview of Part 3 (presentation of the data)

The interpretive procedure that was employed in the research was adapted from the work of feminist psychologists Brown and Gilligan (1992). While this study is not feminist in orientation in that it doesn't specifically examine gender as a key organizing factor in the construction of our social and subjective identities, and the perpetuation of injustices and inequalities, the use of an adapted version of Brown and Gilligan's 'voice-centred relational method' was valuable in facilitating a focus on matters of voice and perspective within the contested and power-laden field of mental health practice. The method was also congruent with the postmodern orientation and overall aims of this study. The method entails two distinct stages: firstly, the individual interview transcripts were read from multiple positions, facilitating exploration of the polyphonic nature of these texts. Following this, a process of generating connecting themes across the data-set as a whole, (including data from a range of sources) occurred. The first stage of Brown and Gilligan's method is particularly intensive, and produces a large volume of ideas and associations relating to the individual transcripts, which then need to be connected together meaningfully to create relevant themes, in the interests of narrative coherence. Revisiting the research aims at this later stage of the 'journey' therefore provided a helpful structure with which to engage with the wealth of ideas generated during the initial stages of data-analysis. The broader themes generated in this latter phase provided the range of headings under which data are presented in the next section of the thesis.

The data presentation chapters

The presentation of the data within a research text necessarily entails reduction. In order to produce a focused, readable account the researcher makes choices about relevance, about what to include and what to leave out. There are several risks associated with this process of imposing structure onto an unruly mass of qualitative data. The richness of the data might easily be lost in the process of trying to differentiate what is 'baby' and what is 'bathwater'. Chenail (1995) discusses the value of juxtaposition in presenting qualitative data as a means of highlighting complexity. In the chapters that follow I have therefore made use of juxtaposition in presenting extracts from the data in a manner that aspires to preserve something of the richness and variety of the data-set as a whole. Comments from participants who were speaking from different social positions, (service-users, family members and staff from different professional disciplines) are juxtaposed with the aim of re-presenting a spectrum of views. I have also juxtaposed quotations from research participants with my own comments and reflections in relation to particular themes. Journal notes and data from secondary data sources are also threaded into the weave as well as themes from the previous literature in this field, to further enrich the pattern which is constructed. As the overall aims of the research were essentially concerned with matters of voice, my intention has been to create a text which has a polyphonic texture by weaving multiple voices into the discussion.

The major themes that were generated through the process of data-analysis are presented and developed in four sections:

1. **The relationship between the reception meetings and their organisational context (chapter 7).** Exploration of this relationship was a key aim of the study, and the pertinent data is presented to provide the reader with an understanding of the wider organizational context within which the reception meetings occurred. The perceptions of staff regarding the meetings, and how these perceptions are shaped by contextual influences is considered. The theme of the reception meetings as a disruption, sometimes welcome and sometimes not, to the usual pattern of events in the research site is also developed in this chapter.

2. **Dialogue, monologue and the authority of the medical voice (chapter 8).** The dominance of the biological perspective in psychiatric hospital settings creates specific challenges for the introduction of postmodern, dialogical approaches to practice, and this area is explored in this section. Data regarding participants' views about the presence or absence of senior medical staff in the reception meetings are discussed. In particular, some problems associated with attempts to open conversational spaces for alternative ways of talking and understanding by ignoring or minimize the centrality of the medical voice are highlighted.

3. **The reception meetings as occasions for dialogue: opportunities for speaking and hearing in the meetings (chapter 9).** Multiple narratives about the opportunities and constraints that were experienced by participants in relation to acts of speaking and hearing are explored in this chapter. In other words, the stories told in the research regarding experiences of being in dialogue with others, and also of managing potential interpersonal conflicts within the reception meetings are examined. Since a primary aim of the reception meetings was to create a forum in which dialogue could occur between families and staff, this was a key area of enquiry within the research.

4. **Postmodern practice in the reception meetings: the co-creation of opportunities for dialogue (chapter 10).** This fourth section explores data pertaining to the contributions of members of the reception meeting team within the meetings. These accounts of team members' contributions are considered in relation to discussions within the postmodern family therapy literature regarding issues such as the 'decentred' therapist position and the therapeutic relationship (White 1995); the creation of contexts of 'safe uncertainty' as a prerequisite for dialogue (Mason 1993); and the use of reflective processes as a catalyst for dialogue (Andersen 1995).

Part three:

Presentation of the data

Chapter 7. The relationship between the reception meetings and their organizational context

Commentators from the fields of systemic practice (Cecchin 1993) and qualitative research (Heritage 1997) have drawn attention to the influence of wider systems such as organizations and instititutions in shaping the perceptions, experiences and identities of the individuals who inhabit or interact with them. From a systemic perspective, it is the cultures that we inhabit that provide us with the beliefs, values and expectations that inform our lives (Stratton 1998). Culture is a term that can be difficult to define precisely, since it tends to be used in diverse ways within different texts. Pearce (1994) has suggested, however, that it is preferable that there is no definitive definition, as the word 'culture' denotes a 'relationship' rather than a reified 'thing'. He evokes the metaphor of darkness or mist that surrounds us but which dissipates when we try to shine a light on it to see it more clearly. Culture tends to be invisible to the people inhabiting it, but plainly visible to those from different cultures. In relation to this study, the organizational culture of the research site inevitably impacted upon the ways in which participants regarded the reception meetings, and how their opinions and expectations of the meeting were organized.

As discussed in Chapter 2, the culture within psychiatric hospitals tends to be orientated towards reductionist, biologically-oriented modes of thought. As a consequence, there is a strong emphasis on physical methods of treatment such as medication as primary forms of intervention. Consequently, a number of commentators have expressed concern about the counter-therapeutic climate prevailing within these environments (Dept. of Health 1999b; Johnstone 2002; Moore 1998). The reception meetings were therefore introduced into an environment which often felt fraught and overstretched, as is indicated in the data that will be presented in this chapter. To gain an understanding of the reception meetings and the experiences of people who participated in them it is therefore crucial to consider the broader context of the Unit, and the ways in which this environment shaped people's perceptions of the meetings. A primary aim of this research was to consider this complex relationship between the meetings and the organizational setting of an acute psychiatric in-patient Unit, and to consider the practice implications that arise from an examination of this relationship.

The discussion in this section will initially focus primarily upon data regarding the perceptions of staff in relation to the reception meetings, and how these perceptions may have been shaped by the culture and organizational structure of the Unit. This is not because I am privileging the views of professionals over those of service-users or family members in the research, but rather because staff play a particularly significant contribution in maintaining the culture of institutions. Staff in an acute admissions unit have a longer-term presence, whereas service-users and their families tend to have a more brief involvement with the organisation. Staff views about the reception meetings were therefore crucial in influencing the ways in which the service was initially presented to service-users and families, as well as the extent to which the meetings were successfully implemented over time.

Stories about resources, service priorities and staff roles

The introduction of any new service within a health care organization carries resource implications, and, as previously noted, problems associated with the inadequate funding of psychiatric in-patient units have been well documented in the literature over the past few years (see, for instance, Johnstone 2002). Similar concerns featured in conversations about the reception meetings with staff from the research site. This was a particular issue for members of the nursing team, who held primary responsibility for the smooth running of the Unit on a 24-hour basis, and were often in a position of having to juggle scant resources. Dan[1], a staff nurse on the Unit, describes some of the associated pressures that were experienced by staff:

Dan: Sometimes in the Mixed area of the Ward there's 27 patients and four staff, two observations rotas, say me as a coordinator for the shift. That leaves one person for the Ward, so what's happening to the other 25 clients? OK, some are on leave, but generally they're left to their own devices. The Ward's too big, and every other day you're looking for staff. And you know, if there's a reception meeting coming up, and a Ward representative needs to be there, it seems... (sentence not completed).

Dan indicates here that there were issues of scale which made the Unit particularly difficult to manage. Against this background of low staffing levels and a relatively large

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[1] The names of all participants have been altered to preserve anonymity.

service-user population, the introduction of reception meetings was at times perceived as yet another activity competing for the staff's scant resources:

Alex: Do you feel that people in the nursing team are moving towards seeing them (the reception meetings) as useful or less useful?

Dan: It depends what day you ask them! How busy things are. I know sometimes its an excuse, "The Ward's busy", or "We're short staffed", but honestly Alex! It's the biggest Ward in the organization, and... although they're very important, the reception meetings, and I genuinely believe that, but depending on what day its on, sending a Ward representative leaves the Ward short, and that causes a bit of trouble[2].

Dan's remarks are contradictory in some respects: on the one hand he expresses the view that the reception meetings are an important service, but his comment that *"sending a Ward representative leaves the Ward short"* suggests that he regards the meetings as peripheral to the 'core business' of the Unit; that this is an activity that depleted Ward resources which might more properly be diverted towards other activities. Dan's concern that *"sending"* a member of staff to a reception meeting can *"cause a bit of trouble"* within the team suggests that this perception of the reception meeting as a peripheral activity in the context of limited resources was shared by colleagues.

Joe, a nursing support worker on the Unit discussed similar organizational issues to those raised by Dan such as poor staffing when discussing the perceptions of the nursing team regarding the reception meetings:

Joe: Some people would say that they're an absolute waste of time, others would say they're absolutely essential. They're important. You see, I think its all to do with priorities on the Ward. If you've been incredibly busy trying to find staff for the Ward, then you see lots of bodies around, and you say "What are they doing?", "Oh, they're doing the reception meeting", it might seem like totally low priority in comparison with high priority things on the Ward, like observations and things[3]. There's an element of that. If there was no observations at all, I think people would take much more notice of reception meetings.

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[2] A full interview transcript is provided in appendix 3, part a, to provide a more detailed picture of the interview procedure.
[3] See Chapter 3 for an account of the 'observation' policy which was in place on the Unit. In brief, this is a procedure whereby staff maintain constant or regular observation of service-users who are identified as at risk of harming themselves or others.

The fluctuating demands on nursing staff appeared to contribute to the creation of a rather unstable culture in which the priorities of the nursing team tended to shift according to the numbers of staff available and levels of activity on the Unit. Both Joe and Dan suggested that the views of the team regarding the value of the reception meetings might vary from day to day as a result of these factors. Boscolo and Bertrando (1993) propose that a key element of the culture of any human system is the psychological orientation towards time. Within the culture of the nursing team it might be said that there was an orientation towards the more immediate challenges of the moment, potentially making it difficult to engage in activities such as reception meetings in a planned or consistent manner. Smith and Vetteman (2002) also argue that over recent years there are increasing demands on psychiatric staff that lead to a service orientation towards crisis work rather than more planned or 'considered' approaches. These authors also suggest that the competing demands on staff time which contribute to a crisis culture within mental health services create a particular barrier to the routine implementation of family-based approaches, since workers may simply not have the time to engage in this more specialized form of practice or to receive appropriate support through attendance at training and supervision sessions.

Both Joe and Dan also indicate that finding sufficient staff to cover shifts was a core activity for the nursing team. Joe's account also suggests that this activity was rather depersonalising in its effects upon staff. He spoke, for instance, about *"seeing lots of bodies around"* at the reception meetings; *"bodies"* who are needed to undertake activities which are considered *"high priority"*, such as undertaking 'observations'. It might be assumed that for staff working in a context where they are at times regarded as depersonalised 'bodies', there will be an impact upon the quality of their interactions with service-users and families. Tasks such as 'observing' service-users, for instance, do not necessarily entail a personal relationship with the 'other', whereas activities such as the reception meetings in which the aim is to generate dialogue require participants to be more fully 'present' as human beings. Or, as Buber (2000) has suggested, dialogue requires of participants a reciprocal "I-Thou" relationship, rather than a depersonalised "I-It" relationship.

The tensions between a 'risk management culture' and a 'therapeutic culture' have been identified in the previous literature regarding acute admissions units (Dept. of Health 1999b; Moore 1998), and are highlighted in the comments made by Joe. Activities such as the reception meetings, which entail staff talking with service-users and their families about the experience of hospitalisation are *"totally low priority"*, in Joe's words, by

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comparison with carrying out 'observations' upon service-users. Bowles (2002) has argued that the emphasis placed upon undertaking observations within acute admissions units mitigates against meaningful engagement between staff and service-users:

The most dominant practice in acute psychiatry has become formal observation, often a demanding, boring and ritualistic pastime of precious little benefit to the patient. After a few hours of carrying out 'obs', few nurses wish to spend further time with patients. (Bowles 2002, p. 26).

In addition, Bowles contends that whereas risk management activities such as 'observations' are frequently a major focus of attention in managerial, supervisory, and audit activities, therapeutic engagement is not similarly emphasized.

Professional hierarchy and perceptions of elitism

Professional hierarchy was an additional factor which potentially impacted upon staff perceptions of the reception meetings. While over time the reception meeting team comprised staff of different levels of seniority within the organization, the group of staff who initially conceived of the service occupied relatively senior roles, including for instance, a consultant psychiatrist, a university lecturer with an honorary clinical contract, and myself as a senior nurse. This may have contributed to a perception that the reception meetings were the special province of an elite group of staff. This issue is highlighted in the following extract from my research diary[4] which was written immediately following a meeting of the reception meeting team that occurred in 1997, during the early stages of implementing the new service:

A concern about the danger of exclusiveness was expressed: "Are we an exclusive group? What do other in-patient staff feel about the meetings?" One member of staff was cited as describing the meetings as an irritation, more work.... Brigid (a nursing support worker on the Unit who had recently joined the reception meeting team) received the comment, "You're one of the elite now!"

Nursing, particularly as practiced within hospital settings, tends to be a rather hierarchical profession, and at the time that the data was collected for this study a

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[4] Extracts from the research diary are presented in appendix 3, part b, to provide the reader with a more detailed picture regarding this data source.

clinical grading system was in place which included 6 different levels for qualified nurses, each with distinct roles and responsibilities. Although Brigid occupied a junior position in terms of formal hierarchy, there appears to have been a perception amongst some members of the nursing team that she had become elevated into the ranks of the elite through her involvement with the reception meetings. This perception of elitism was likely to have created a dilemma for staff regarding involvement in the meetings if it compromised their membership in the wider peer group of 'ordinary' staff.

It is important to consider how my own position within the nursing hierarchy may have contributed to this perception of the meetings as an 'elite' activity. As a nurse at the top of the clinical hierarchy, I occupied a position of relative authority within the Unit. In addition, the reception meetings tended to be perceived as 'my baby' in the sense that I was known to have a strong interest in developing services for families, and I was broadly responsible for coordinating the reception meeting team by arranging team meetings and organizing a rota for staff who were hosting the meetings, as well as carrying out this study. The centrality of my position may well have contributed to a view amongst the nursing team that the meetings were a 'top down' development, despite the aspirations of myself and the other reception meeting team members that this should be a collaborative venture which was 'owned' by the staff team as a whole. This raises more general questions about the implications for organizational development when the person attempting to act as a change agent occupies a senior position within the system. Selvini Palazzoli (1984) raises a similar point when she advises family therapists who are involved in consulting to professional systems to avoid becoming involved in alliances with senior figures within the organization. While such alliances may initially appear to offer a route to systemic change, they may simply result in the family therapist becoming ensnared in the complex power dynamics of the organization.

Staff roles and responsibilities

Faced with the dilemmas associated with these cultural factors and the demands of juggling scant resources to maintain the operation of the Unit on a 24 hour basis, it would have been understandable if nursing staff at times felt reluctant to arrange reception meetings when a service-user was admitted. Throughout the data-collection phase of the research there was an ongoing concern amongst the reception meeting team about the number of instances where meetings were not arranged when people entered the Unit. The erratic nature of the process of introducing the reception meetings into the

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everyday culture of the service is highlighted in diary entries I made during this period, all centred around the same issue. The following entry, for instance, is illustrative of the organizational issues that were encountered:

Several meetings cancelled following a mix-up over how to arrange them. One of the community mental health teams asked Jill (Unit nurse) to arrange a series of reception meetings. Jill was unsure of the procedure and booked several meetings into the file, but without informing the service-users, relatives, etc., so nobody else knew about the appointments! ...Jill had spoken with the Ward Clerk, who had apparently queried whether the families concerned knew about the meeting dates, and Jill replied, "It's not my job, it's the primary nurses job, and she's on holiday!".

The perception of staff that staffing levels were inadequate on the Unit, along with the complex system for organizing nursing care that had been developed as a response, appeared to contribute to the development of an ethos where it was unclear where responsibility lay for undertaking particular activities, (See Chapter 3 for an account of the system for organizing nursing care that was in operation during the data-collection phase of the study). Jill had been willing to book appointments into a diary when asked to by colleagues, but not to undertake the crucial step of informing the service-user and family of this arrangement; she saw this as the role of the 'primary nurse', and she was simply acting as the 'ward representative'. Convening network meetings can be a complex and time consuming task (Speck 1998), and in a pressurized working environment where staffing levels tended to be low, individual members of staff might also have felt reluctant at times to undertake activities which they didn't regard as central to their role.

A further problem associated with this sense of feeling overstretched amongst the nursing team was that, on several occasions, the 'primary nurse' for a particular service-user was not available to attend the reception meeting. The absence of the primary nurse seemed to create something of a 'domino effect', leading to related problems regarding roles and responsibilities for colleagues from the community-based teams. One example of this is highlighted in a letter that was sent to me by Jack, an occupational therapist who was also a member of the reception meeting team. The letter was written following a reception meeting arranged for a young man named Nick, who entered hospital under the Mental Health Act (1983). As well as Nick and Jack, the meeting was also attended by Nick's parents and a nursing support worker from the Unit, and Glenda, a social

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worker who was also a member of the reception meeting team. In his letter Jack expressed concern that no 'suitably qualified' member of the Unit nursing team was available to attend a meeting that he had hosted:

There was no qualified or knowledgeable member of ward staff present. Given that many of the parent's concerns are about what does (or doesn't) happen on the Ward, I wonder how concerns are fed back up the system?

Jack goes on to say that in the meeting it had emerged that the family were *"alarmed by several things"*, including:

- *Lack of activity on the Ward*
- *Difficulties resulting from leave policy decisions taken by consultant and nurses*
- *Worries about a forthcoming appeal (the service-user concerned had lodged a formal appeal to a Tribunal against his detention under the Mental Health Act)*
- *Having to relate to so many professionals*

Writing about his own experience of being in the reception meeting, Jack commented:

The family were warm and cooperative and I feel that it was a useful and positive meeting, but I guess I am left sharing some of the family's frustrations. I know Glenda and I helped create some necessary and important talk, but there were also times that I felt like some impotent functionary, while offering empty reassurance that a complaint had been heard, (the word 'complaint' here is too strong, but I think you know what I mean?). I felt all the more useless wondering if half of what had been said would get back to the relevant people, given the lack of ward representation. And I was potentially just another professional passing through.

The experience of participating in this particular reception meeting appeared to have been complex for Jack, raising feelings of both achievement and also frustration with what he regarded as the shortcomings of the service. This is reflected in a comment he made later in his letter, *"Perhaps I am still feeling rather caught up in some of the powerful feelings that emerged during the meeting"*. On the one hand, he viewed the conversations that occurred in the meeting as *"useful"*, *"important"* and *"necessary"*, and felt that as a facilitator he had helped to create the opportunity for these discussions to occur in a positive manner. At the same time, however, he also appeared to have

experienced powerful feelings of helplessness in the face of the family's expression of concern about the services delivered on the Unit. Jack expressed frustration that there was no 'suitably qualified' member of the nursing team present to respond to these concerns.

Stories about the influence of organizational context on staff experiences of participating in the reception meetings

Data generated in this study suggest that organizational factors shaped staff perceptions not only *of* the reception meetings, but also influenced their experiences of participating *in* the meetings. A number of the staff members who took part in the research spoke about the manner in which their experiences of the meeting were coloured by organizational concerns or by the professional roles that they inhabited. These organizational requirements and roles often seemed to be constraining in their effects upon staff, rather like a garment that fits too tightly.

Speaking from his position as a consultant psychiatrist, John discussed his experiences of a reception meeting that was organized when a young woman called Christine entered hospital under the Mental Health Act (1983). John was the doctor who held medical responsibility for Christine's care, and he had therefore been responsible for arranging her detention in the Unit. In the following extract, he spoke about events in the reception meeting in a manner which suggests that he felt the discussion was disempowering for Christine:

John: The thing that sticks out most clearly is ...., well I'll use the form of words that first comes to mind, I heard Christine buying into the family account for the first time. The family account of, "She's defective, and she needs fixing". ...this very strong contrast of her fitting in and doing a lot of agreeing.

John's perception of events in the reception meeting was that Christine had somehow given up *"arguing her corner"* and capitulated to the family's account of her as 'ill'. In other words, from John's perspective, a process of interpersonal 'closure' between Christine and her family had been amplified rather than prevented in the reception meeting. Later in the research interview, however, John went on to discuss how his

negative perceptions of the discussions that occurred in the reception meeting were linked with his own role within the wider organization:

John: I suppose thinking about trying to work reflectively, getting those family and staff members in the room, and trying to make this a forum where some kind of reflective thought could take place, it didn't seem to be working, in my narrow definition of 'working', but eh, if anything the discussion had closed down. Now that's almost certainly nothing to do with the forum itself, it probably has a lot more to do with me being the person that's responsible for "boxing her up" on the Ward, so there's probably some misgivings about my role in all of this scenario that's part of that too. Yeah- I think I've over-experienced that in some way, because, although there was this sense of Christine towing the family line, I'm also aware that it didn't close off the discussion to the extent that I was, prejudicially, expecting.

John linked his sense of frustration about the conversations *"closing down"* in the reception meeting with the custodial dimension of his own organizational role. His experiences and perceptions of events in the reception meeting were therefore negatively influenced by the social control dimension of this role.

For nursing staff in the research site, the experience of participating in the reception meetings was also, at times, strongly influenced by their roles within the Unit. In particular, the complex system for delivering nursing care that was in place on the Unit during the data-collection phase of the research crucially influenced not only whether nurses were able to attend the meetings in the first place, but also the ways in which they might feel able to participate in the conversations when they did attend. The nursing system frequently resulted in situations occurring where individual nurses were required to attend the reception meetings, (and other meetings within the service) as a 'ward representative', although they may not have had any prior, first hand contact with the service-user for whom the meeting had been arranged.

Colin, a community psychiatric nurse (CPN) who had previously worked on the Unit discussed his past experiences of attending reception meetings as a ward representative and how this contrasted with his subsequent experience of participating in the meeting as a community based professional:

Colin: I think that now (as a CPN) I go to the reception meetings more or less as a practitioner in my own right, with the confidence to say, "This is my opinion", whereas I

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think its quite restrictive on the Ward, when you're an individual going along, you don't necessarily go along with someone you're actually working with. You're taking someone else's opinions, and you feel... well, I personally felt a little bit restricted and I doubted whether what I was saying would be useful, just... (pauses)

Colin's experience of attending reception meetings as a ward representative was therefore one of feeling constrained and unable to participate in a 'personal' way by giving voice to his own opinions. Instead, he was acting simply as an agent of the team, passing on the opinions of others without any clear idea about the value or usefulness of the information. He continues:

Colin: ...Rather than working as an individual, you'll be chasing around the Ward, because you're going to this meeting, you'll be chasing around, "Where's the notes, who is it, what's happening here?" So you go to the meeting and you're reciting what you've learnt in the last day or so... I think if you can add opinion to the information, if you can go and say... (pauses) ...it's much more useful than giving just the basic information from a Ward point of view.

Colin's account highlights the difficulties that nursing staff might experience when speaking from *"a Ward point of view"* in the meetings, a process of simply *"reciting what you've learnt"* from written notes or from brief conversations with colleagues. Under these circumstances, the 'ward representative' is unable to speak 'personally', in the sense of sharing his or her own opinions which have been formed in direct interactions with the service-user.

Dan, a nurse on the Unit, spoke in a similar manner to Colin about the difficulties associated with the role of 'ward representative':

Dan: Sometimes you're there as the ward representative, and you go there and then... afterwards you don't really feel part of it. But the primary nurses can't always be there, its left to the ward representative, and sometimes they can be put in a sticky situation if they're not familiar with the client. If you've been off from Friday to Monday, you come in Tuesday and there's a meeting for such and such, you're the ward representative!

Members of the nursing team who were attending the reception meetings as a 'ward representative' might therefore experience feelings of awkwardness as well as a sense that they are unable to contribute anything very valuable to the process; they were in a

"sticky situation", as Dan said. Rather than feeling able to participate in an engaged manner, the person may feel that they are simply 'reciting' the views of others without being able to contribute anything of their own.

The designation 'ward representative' implied that the activity required of the nurses in the reception meeting was to provide and receive 'information' about the service-user, much as in physical health-care settings a nurse might comment on how the 'patient ' was progressing in a medical ward round. In other words, the notion of the 'ward representative' held at its centre the model of a relationship between the nurse and service-user in which the service-user was the 'object' of professional knowledge which had been generated by the nursing team on the basis of observation and assessment. This conception of the professional / service-user relationship which is predicated on the notion of a 'known object' (the service-user) and a 'knowing subject' (the professional) stands in contrast with the idea of a dialogical relationship in which understanding is jointly created through an encounter between two or more people, who never fully understand one another (Saukko 2002). For nurses in the research site who attended the reception meetings as a 'ward representative', participating in a dialogical process of this kind within the reception meetings might frequently have been experienced as a challenging and complex task, particularly if their expectations of their role were shaped by more traditional, medicalized narratives regarding the 'nurse-patient relationship'. Since one of the primary aims of the reception meetings was to create a forum in which dialogue could occur between those who attended, the organizational 'reality' of limited resources created a context that was at times rather unconducive to the realization of this aspiration.

Stories about perceived benefits to the Unit of the meetings

While the discussion so far has principally addressed organizational constraints and areas of tension in relation to the introduction of the reception meetings, this was by no means the total picture, otherwise the project would never have evolved beyond the conception stage. One important source of positive feedback which led some staff to feel well disposed towards the meetings was from the families themselves. Over time, some key members of the nursing team became aware of the potential benefits of the reception meetings in relation to their impact upon the ways in which families perceived the Unit. This is highlighted in the following extract from my research diary, following a discussion with Dave, the ward manager:

Dave mentioned to me that since the reception meetings have been occurring regularly he hasn't been receiving complaints from relatives or carers, which were such a regular event previously.

While complaints are an important source of feedback which can assist professionals in improving the service they offer, they can also be demoralising for the staff team, particularly if they are received frequently; most people would prefer to receive compliments about their work rather than criticism. Dave's attribution of the fall in the level of complaints to the reception meetings was therefore potentially important to the successful implementation of the project within the Unit. As ward manager, he held responsibility for the everyday running of the Unit, and so it was crucial that he was supportive of the meetings.

Similarly, Mark, a charge nurse on the Unit, reported receiving very positive comments from a family member regarding a reception meeting, as the following extract from my research journal indicates:

Discussion over the phone with Mark regarding a recent reception meeting. In the meeting, the service-user's mother commented more than once, "This has restored my faith in the mental health services". The family had had some difficulty arranging psychiatric assistance for their son, and had eventually sought private care, because of the difficulty they had experienced through the NHS. The reception meeting was the first time that the family had been offered the opportunity to come together with staff and discuss the situation.

Prior to receiving this feedback about the positive impact of this particular reception meeting, Mark was already enthusiastic about the idea of the meetings and had become involved in the reception meeting team. Hearing comments of this nature from a family member who had previously felt disillusioned with the service would be likely to have the effect of reinforcing his commitment to the implementation of the meetings, however.

Summary and discussion

The work of psychiatric staff is often characterized by a tension between what they might hope to achieve, and what actually feels achievable in particular circumstances. It is crucial to emphasize that the organizational difficulties that have been discussed in relation to the research site for this study were not unique to the local setting, but reflected issues that have generated concern at a national level. Johnstone (2002, p.1), for instance, describes in-patient nurses as receiving *"too little support, training, and supervision"* to deal with the complexities of the situation that prevails in these environments. She paints a grim picture of the pressures facing staff:

"Entire shifts consist entirely of crisis management, with no time for staff support or debriefing or doing anything remotely therapeutic with the patients. ...Nursing staff are stretched to their absolute limits; my former nursing students, now out on the wards, seem to be struggling to hold onto some shreds of idealism and compassion". (Johnstone 2002, p.1)

Johnstone's stark description echoes the accounts provided by nurses who participated in this study regarding their struggles to support and contribute meaningfully to the reception meetings in a fraught environment which frequently required them to juggle scant resources in order to maintain the service. Faced with these organisational constraints, priorities shifted for staff from a concern with engaging service-users and their families in reflective conversations towards a basic preoccupation with safety and the management of risk.

Professional relationships within hospitals can be extremely hierarchical, and cultural factors associated with staff hierarchy created additional constraints to the implementation of the reception meetings. Perhaps because the group of staff who initially conceived of the reception meetings, including myself, occupied relatively senior posts, this new service development was greeted with a degree of scepticism from staff, who appeared to regard it as an elite activity. This data raises important questions about how effectively organizational change can be initiated from the 'inside' by someone who occupies a senior position within the system, and how this issue of hierarchy needs to be addressed in the earliest stages of the change process.

In considering the relationship between the reception meetings and the complex and sometimes ambivalent organisational culture of the Unit, questions can also be raised regarding the extent to which the initial goals of the reception meetings, as formulated by the group of staff who initially conceived of them, were achievable in this setting. Amongst the aspirations of the reception meeting team was that the meetings would provide a site where dialogue could occur between participants. Engaging in dialogue requires of the participants that they render themselves vulnerable to a degree, that they risk speaking more 'personally' in the sense of allowing themselves to be surprised, and even transformed by the response of the other (Anderson 1997). In a context where staff inhabit organisational roles which are experienced as constraining and frustrating at times, the degree of 'response-ability' that they feel able to adopt may be limited. Under such circumstances, speaking more openly and more 'personally' may feel too risky or the person may feel that they does not have sufficient knowledge of the service-users situation to usefully contribute to the conversation.

It might be argued, however, that the organisational constraints operating within the Unit meant that the reception meetings were all the more important as a service. Without these meetings, it was unlikely that the service-user, their relatives and members of staff would find an opportunity to sit down and talk together for any significant period of time. A survey by the mental health advocacy group MIND identified that in many acute admissions units service-users receive little more than a few minutes per day with a member of staff (MIND 2000). This gloomy picture is supported by views expressed by Frank, one of the service-users who participated in this study, who commented that, *"the Ward would have been like a holding pen if not for the reception meeting"*. Whereas for members of nursing staff who were juggling scant resources the reception meetings may have at times been viewed as an additional demand on their time or an unwelcome disruption to the running of the Unit, for service-users this disruption may have been much more welcome. For some, like Frank, the reception meeting may have provided the first opportunity that had been offered to talk in any depth about their situation since entering hospital. Positive comments from the families themselves regarding the meetings appear to have been an important factor in influencing some members of the nursing team towards feeling more well disposed towards them.

Chapter 8. Dialogue, monologue and the authority of the medical voice

"The present hierarchies of our culture, schools and family- and thus of mind- do not deeply invite dialogue; neither does the voicelessness directly resulting from such hierarchies of power". (Watkins 1999, p. 266).

The diversity of narratives that have been developed regarding the nature of 'mental illness' result in psychiatry being a contested field. Theoretical and ideological differences frequently lead to tensions arising between professionals who are aligned to particular accounts of psychiatric disorder and related treatment modalities. In relation to in-patient settings, the hospital stands as a powerful symbol of the authority of the medical narrative (Johnstone 1994), and the dominance of the medical model within in-patient settings is consequently a source of tension and resentment at times, as proponents of psychological or social models may struggle to have their ideas taken as seriously as biologically-based approaches. While the tensions and ambivalences which are generated in response to the supremacy of the medical voice are occasionally discussed 'openly' at multi-disciplinary meetings and other 'formal' occasions, Good (2001) suggests that dissenting voices are more frequently heard outside of these formal contexts; that is, in alternative spaces such as corridors, coffee rooms, car parks, and so on.

A key aim of the reception meetings was to create a site where dialogue could occur between participants, that is, where a polyphony of voices might find expression. This aim in some respects ran counter to the cultural context of a psychiatric hospital which holds at its ideological centre positivist notions regarding the objective truth of certain 'scientifically validated' narrative accounts. Good (2001, P. 217) comments:

"I cannot pretend that polyphony is not a challenge to the administrative and medical demands that are made upon the practitioner. The assessment of madness continues to refine diagnostic and treatment regimes against approved frames of reference. And the utterances of practitioners are refracted through permutations of standard formats. Accordingly, the reality of any dialogue is hampered by the practitioner's sideward glances to the more elevated sites of meaning".

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The tensions associated with attempting to introduce a postmodern form of practice which aspires to engage with a diversity of voices into a context where modernist notions regarding the importance of arriving at a single, accurate formulation or diagnosis to inform 'treatment' was therefore a challenging enterprise. In this section I will therefore present and discuss data which addresses the ways in which the dominance of medical narratives within the research site influenced the perceptions of the research participants regarding the reception meetings.

Whilst it is over-simplistic to equate particular professional disciplines with specific narratives regarding psychiatric disorder, (doctors with a medical model of distress; psychologists with psychological models; social workers with social models, and so on), assumptions of this sort frequently seem to be made in practice situations. The dominance of the biological view and the authority that tends to be, by association, conferred upon doctors was an area that held important implications for this research. For some of the participants in the study, medical staff were regarded as authority figures whose elevated position conferred special insight or expertise. Responses to this perception of medical staff as authoritative 'experts' were complex and occasionally ambivalent, however, with some participants viewing the expertise held by doctors as being of a rather blinkered, one-dimensional nature. In discussing the participation of doctors in the reception meetings, some participants also suggested that their presence or absence was a crucial factor in determining what might be spoken about.

Stories about the presence or absence of psychiatrists

Attendance at reception meetings by staff tended to be influenced by a number of factors, including the preferences of the service-user and family; the timing of the meetings and availability of staff; and the willingness or otherwise of individual staff member to attend. The number of medical staff involved in the research site fluctuated during the data-collection phase of the study, partially as a consequence of a difficulty in recruiting doctors that the organization was experiencing at the time. There would generally be approximately 4 or 5 consultant psychiatrists who were involved with the Unit to some extent during this period, but these senior doctors also carried additional responsibilities for large out-patient populations. There was also a similar number of more junior doctors (Senior House Officer level), who provided additional input into the Unit. In the majority of instances, there was no medical staff present at the reception

meetings: of the 85 meetings that occurred between January 1998 and July 1999, clinical records indicate that a doctor was present on 18 occasions (20%).

For some participants, the absence of a doctor at the reception meeting evoked a sense of relief, as they felt that the conversation flowed more freely, and around a wider range of topics, when medical staff were not directly involved. Holly, a psychiatric nurse on the Unit, commented:

Holly: I think it's good to have a meeting without doctors. I think clients say different things to doctors. I've seen it, I've heard it with my own ears, they just change what they're saying. I think there's this thing of doctor's being god-like, isn't there? I mean, it's a bit like perhaps avoiding any real issues, "Let's get the tablets".

Holly continued to elaborate upon her comments regarding how the conversations that occurred in reception meetings would be constrained by the presence of medical staff:

Holly: Well, I think that people would feel more intimidated, those people who are already intimidated by the meetings. "Psychiatrist", "Consultant", that's a frightening word as well, isn't it? So I think that they'd be more intimidated. In any case, you don't want the reception meetings to be about medication only, or even about diagnosis, so I'm not sure how involved doctors would want to be in the rest of the things that get discussed at reception meetings.

In Holly's view it was an inevitability that the involvement of medical staff within reception meetings would have a narrowing effect upon the conversations that occurred. This was not only because the service-user would feel unable to speak openly in the presence of such powerful figures, but also because the medics themselves would not be interested in participating in talk which wasn't focused upon their particular area of expertise, medication. In Holly's view, the cultural stereotype of the 'god-like' doctor whose interest doesn't extend beyond the prescription pad was not only powerfully operational in the minds of family members, but also in the minds of the doctors themselves.

Similar views regarding consequences of doctors attending the meetings were also expressed by Vicky, from her perspective as a service-user. Vicky identified a clear distinction between the kind of discussion that she would have with medical staff and

the discussion that occurred in the reception meeting, and went on to suggest that the presence of a doctor in the reception meeting would have been inhibiting for her:

Vicky: No, I don't think the doctor should be part of the meeting. No, because it makes it too... it would make it too intense, because you would feel, eh.. what's the word? Em, if the doctor was there... I can't describe how I feel... I think it would have been, not threatening, it would have been, eh, more like a hospital, doctor thing. Whereas without the doctor there it was casual, and far more.... So I think if there was a doctor was there sitting taking notes, I wouldn't have been able to say half of the things that I said. It would be too formal, I think, I think that's the word, formal, if the doctor was there. But without the doctor it was very informal.

This image of the doctor as a detached observer, silently recording what is being said, is extremely powerful, and emblematic of a context in which monological communication prevails. Encapsulated within this image is the 'knowing observer' and the 'known object' dichotomy; it is an image which stands in sharp contrast with the notion of a dialogical encounter in which understanding is communally generated and is always fragmentary (Saukko 2002). For Vicky, the sense of formality associated with being in the presence of a medical expert was a potential constraint in her struggle to find her own voice. Watkins (1999) suggests that in social conditions where monologue prevails, the participants who inhabit less powerful positions in the encounter may also experience inner oppression as their 'internal voices' become silenced. Under such circumstances, an experience of voicelessness in the face of authority may result.

By contrast, Vicky identifies the 'informality' of the reception meeting as being an important factor in allowing her to open up. Nursing staff, perhaps because of their lower status within the traditional professional hierarchy, were seen by Vicky as less formal figures than doctors and therefore easier to talk more openly with:

Alex: Do you think of the meetings that you have, say with the nurses, as less formal than the meetings with the doctors usually are?

Vicky: Yes, because obviously the nurses can advise and talk to you, whereas when you see a doctor it's more formal, it's "How are you feeling now?" Whereas it's less formal without a doctor there. I mean, nothing against doctors! (laughs) But, yes, I think it would be too formal with a doctor there.

Vicky's account of her relationship with the nursing staff stands in contrast to her relationship with the doctors; the 'knowing subject / known object relationship' that she regards as characteristic of her discussion with the doctors is contrasted with what are perhaps more 'ordinary' or egalitarian relationships with the nurses. As the research interview conversation progressed, Vicky elaborated upon this idea of the medical staff as rather daunting authority figures:

Vicky: I think that's the word, authority figures. I mean, the doctors are wonderful in here, don't get me wrong, but I think it should be a separate thing from the doctor's, the reception meeting. It's less formal, and it's more relaxing. Definitely. Because let's face it, the reception meeting is not a meeting to see how your progressing, is it? It's not a meeting to see how your getting on, it's really a meeting to let people get together and have a nice chat, and say how they feel, and it's informal. Whereas if the consultants or doctors were there, you would feel, "I'll listen to what everyone else thinks", so you would be wary about what you said if the doctors and consultants were there, whereas it's nice and easy and relaxing and informal.

Vicky's preference for the *'informal'* conversations that occurred outside of the presence of the doctors appears to have been linked with a desire to avoid engaging in narrowly focused 'illness talk' which would reinforce her status as a 'patient' who is 'ill'. In other words, she wished to avoid a process of interpersonal 'closure' occurring whereby the problems that she was struggling with were located 'within' her as an individual, and the contextual fabric of relationship which formed the backcloth to her situation was ignored. When discussing her father's request in the meeting for more information from the staff about the nature of her problems, for instance, Vicky commented:

Vicky: I don't think the reception meeting is about that. I don't think that it's about relatives finding out how the state of my mind is and things like that, why am I like this, "Why is she like that?" I don't think the meetings about that.

If a doctor had been present, Vicky feared that this would have derailed the conversation, in the sense that her relatives would have questioned staff about her difficulties; the doctor would have been perceived as the source of authoritative knowledge about the problem, rather than Vicky herself. In her father's eyes, insight into the nature of the problem was the province of the medical experts, and Vicky expressed considerable frustration regarding her previous attempts to have her voice heard by her father in relation to this issue:

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Vicky: Because I've tried to tell him and it's been dismissed, swept under the carpet...
Because if the doctor had been in the meeting... those sort of questions would have been
asked- "What's the matter with her? Why is she like this? How long's she going to be
in?" There would be nothing said.

For Vicky, these questions about 'what is wrong with her' in psychiatric terms, and the expected 'prognosis' were relatively insignificant; if the meeting had focused on these topics, *"there would be nothing said"*. According to Whittle (1996) family members become even more orientated towards illness accounts of the problem when a person enters hospital, and as a consequence, responsibility for creating change is frequently 'handed across' to the professional 'experts'. In addition, the 'mentally ill' are often regarded as lacking in 'insight' into their situation because of impaired perceptions of 'reality', and therefore tend to be regarded as unreliable commentators (Scott 1973). The reception meeting that Vicky and her family participated in appears to have been empowering in this respect; the meeting provided a context in which Vicky's own voice could be heard rather than her story regarding the situation becoming subsumed through the amplification of an illness account.

For both Holly and Vicky, speaking from their respective positions as staff member and service-user, the authority of the medical narrative is such that other ways of thinking and talking are suppressed. These powerful medical narratives are embodied in the presence of doctors, whose authoritative presence is likely to transform the informal, conversational ethos of the reception meetings into an altogether more formal affair. In Bakhtinian terms, heteraglossia becomes monoglossia as the voices of the service-user and family become marginalized in favour of narrow, reductionist talk of 'illness', 'symptoms' and so on (Seikkula 1993). Paradoxically, these medical narratives are viewed by Holly and Vicky not only as being very powerful, but also, at the same time, fairly insignificant in terms of addressing issues of genuine concern. It is in the more informal context of a meeting without doctors present that *"real issues"* can be discussed.

While some participants in the study suggested that they felt there was more freedom to speak about a wider range of issues in the reception meetings when the medical staff were not present, this was not a view shared by all. For some of the professionals who took part, the absence of a doctor was a source of frustration, leading to the discussion

being insufficiently focused on medical concerns.. This view is expressed by Jane, a social worker who attended a reception meeting after Marion was admitted to the Unit:

Jane: Yes, I think that I did view it as an information giving and receiving session, that was from my point of view, and I felt that afterwards, from my point of view, I hadn't got the information that I needed. We hadn't gone through what had led up to the admission, and Marion had mentioned that Dr. Price (consultant psychiatrist) had changed one of her tablets prior to admission and she'd been hallucinating. I don't know if she was still on that tablet, that's why I think she was asking about the medication, and Jim (Marion's partner) was quite concerned about that. I think the pair of them had fixed... the way that Marion had gone was due to this tablet that she'd been given two days earlier, and I don't think that had been cleared up for her, for them, you know? That seemed to be one of the issues that they had both come out with. And there was no Medic there either, there was no notes there to say what she was on. So, that was something we had to go after the meeting and sort out a bit.

Jane is concerned that these recent changes in Marion's medication, which may have been an important aspect of the chain of events leading to her hospital admission had not been addressed in the reception meeting. Whereas some participants welcomed this shift away from a medical focus as an opportunity to discuss a wider range of issues, Jane experienced it as disempowering for Marion and Jim.

Carl, a CPN who participated in the research, also suggested that there is a greater likelihood that the conversations that occur in reception meetings will be dominated by a medical focus when a doctor attends, but he also expressed the view that this is more likely to be problematic in situations where the service-user and family have had limited previous contact with psychiatry and with in-patient services. Carl suggested that for those people who have had extensive involvement with mental health services, discussion abut medical issues such as diagnosis and medication is a familiar and well trodden path which they might expect would occur in the meetings. In the following extract from a research interview, Carl discussed his experience of attending a reception meeting that was arranged when Imogen, a long-term user of services, entered hospital. As well as Imogen, the reception meeting was also attended by her partner Don, members of the ward team, Carl and myself. In this instance, a member of the medical staff was present at the meeting, although she had to leave for part of it in response to a message on her pager. Despite this interruption, Carl felt that the presence of a doctor at the meeting had been important:

Carl: I think it was quite useful that she (the doctor) was there, and it would have been useful if she was there throughout the meeting, because I think Imogen and Don have a lot of questions about medication and all those things, and I think that would have allowed some of those immediate concerns, which would have been extremely important for them, to happen. So, I think it is useful if a medic can attend, for them to attend. Sometimes that then sets the scene for a certain kind of discussion about, "What is my treatment going to be while I'm in hospital? What is wrong with me?", type of questions. But in knowing Don and Imogen, I know that they've had those sort of discussions for years and years, and for that to be different, I think that that's expecting too much in some ways.

One of the aspirations of the reception meeting team was that the discussion that occurred in the meetings would reflect the concerns of the service-user and their family, rather than an agenda being imposed by the staff (Reed 1999). While Vicky and Holly both expressed concern that a medical focus would deflect the meeting from more significant areas of discussion, Carl suggests that for those who have had extensive contact with medicalized psychiatry, this has become the familiar landscape of conversation, and a departure from this focus might be too unusual for them to engage in. Imogen herself was also interviewed for the study, and her comments confirmed Carl's impression that she felt it was useful to bring people together, and that she would have preferred a doctor to have been present for the entire discussion, (Imogen had asked that the research interview wasn't recorded, so the following comments are taken from notes I made immediately after we had spoken[1]):

I asked Imogen what she thought about the idea of the reception meetings, and she said that she thought that they were a good idea, and that Don had also thought that it was a good idea to get people together in this way. I also asked if there was anything in particular that she felt would have improved the meeting, and Imogen said that Dr Joplin kept getting paged and so was coming in and out of the meeting, therefore not getting a clear idea of what was being talked about.

While the perception of medical staff as authority figures led to some participants feeling more free to speak in the meetings when there was no doctor present, others like Imogen and Jane expressed the view that it was preferable that they attended. The

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[1] Further examples of the observational notes I made during the process of practitioner observation are provided in appendix 3, part c, to provide the reader with a more detailed picture of this data-source.

different views expressed by participants regarding the involvement of doctors appears to have been, in part, shaped by different views regarding the importance and desirability of talking about medically-orientated issues such as diagnosis and medication.

As with service-users and family members, individual staff members appeared to hold differing degrees of allegiance to medical narratives regarding problems. For professionals like Jane, who appeared to be immersed in this perspective, an absence of discussion regarding medical factors might produce scepticism about the value of the meeting, whereas for Holly, an emphasis on illness-related talk would be a distraction from more relevant concerns.

Within the medical staff group itself there was also, of course, different degrees of allegiance to illness-based accounts. The medical director for the overall mental health services in the area also provided some clinical input into the Unit, for instance, and was an important source of support for the reception meetings. Another of the consultant psychiatrists, John, was additionally trained as a family therapist. John was also a member of the reception meeting team and a keen advocate for the development of family-based services. For John, the reception meetings were important in that they provided an opportunity for families and staff to talk together productively, without an illness account dominating proceedings and without an emphasis on instrumentally focused discussions:

John: ...you get some people in a room, and towards the end of the meeting, agreements and plans and ways forward are emerging that are unrelated to brain chemistry.

Although the medical staff involved in the research site held much more diverse views about psychiatric problems than the common stereotype of doctors as 'pill pushers' allowed credit for, the authority and status traditionally invested in their role acted as a potential inhibiting factor regarding the discussions that occurred in the reception meetings, regardless of whether the doctors concerned were contributing to the discussion from a medical model perspective or not.

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Summary and discussion

According to Geist and Dreyer (1993), medical science claims to stand above ideology through its objectivity and value free-neutrality, and it is the nature of this knowledge claim which legitimises medicine as a form of social control, as well as shaping dominant cultural stereotypes regarding the doctor / patient relationship. This 'ideologically pure' notion of science and medicine is undermined by postmodernism, however, which places all knowledge(s) within socio-political contexts. Similarly, Bakhtinian ideas about dialogue in human communication disrupt the notion of the doctor and patient as discrete, singular selves, a 'knowing' doctor and a passive patient who is known. Dialogical communication entails both participants as engaging in an interdependent process whereby understanding is produced jointly, and always comprises a mixture of the given (pre-exiting knowledge), and the new (emergent knowledge which is specifically relevant to local circumstances). The traditional ideology of medical care, according to Geist and Dreyer (1993) places constraints upon communication between doctors and the people who consult them, as well as minimizing opportunities for dialogue.

In relation to the reception meetings, attempts to sidestep the complex power issues associated with medical authority by engaging in what might be experienced as more informal meetings without doctors present were likely to result in a different set of problems being generated, however. One unintended consequence might potentially be a re-emphasizing of the illness narratives that participants were seeking to escape or undermine. Colgan McCarthy and O'Reilly Byrne (1995, p. 125) describe a dialogical field as being constituted, *"by the reciting and resiting of many contrasting, diverse and often conflicting stories"*. These authors emphasize that these diverse stories may not be symmetrical, in that some are invested with greater social privilege than others. Failure to recognize and engage directly with these dominant accounts may, however, result in the further disqualification of marginalized accounts. In relation to the reception meetings, for instance, failure to include the medical voice in some meetings created a risk that the marginal status of the reception meetings within the organization would be maintained, along with the alternative voices and stories which found expression in the meetings.

A further disadvantage associated with the non-inclusion of doctors in the reception meetings may be that stereotypical conceptions of medical staff as aloof, one-

dimensional authority figures might remain unchallenged. The persistence of these restrictive stereotypes was a potential source of frustration and loss of opportunity not only to the doctors themselves, but also to the other participants in the meeting who might benefit from opportunities to engage dialogically with these key practitioners.

The creation of conversational contexts in which open dialogue might occur within a social field which is saturated with power inbalances is an extremely complex task. In the chapter that follows, data regarding participants' views and experiences of the reception meetings will therefore be explored, with a particular focus on the extent to which those who took part felt that the meetings presented opportunities for their voices to be heard.

Chapter 9. The reception meetings as occasions for dialogue: Opportunities for speaking and hearing in the meetings

The rationale for the reception meetings, as they were originally conceived of by the team of staff who developed the service, was that they would create a forum where members of the different systems (family, hospital, community agencies, and so on) that come into contact with one another when a person enters hospital could meet and enter into dialogue about this important transition. From a social constructionist perspective, the process of dialogue is in itself transformative as new understandings are built up by those participating in the conversation (Anderson 1997). A dialogical process allows participants to acquire a greater sense of agency over their lives and relationships by discussing the problems and generating new perspectives and ways to move forward (Seikkula, Alakare & Aaltonen 2001).

Social constructionism proposes that our experience of personal agency is intimately connected with the concept of voice, and with the ability to speak and to be heard (McAdam 1995). The experience that one's words have been listened to and taken seriously within a particular setting is therefore an important dimension of dialogue. Such a position can by no means be taken for granted in a psychiatric setting, where service-users are commonly considered to be lacking in 'insight'; a psychiatric diagnosis implies a faulty perception of reality, and one's words may consequently be taken with more than just a pinch of salt.

The different responses of participants to the group setting of the reception meetings and the extent to which they experienced the meetings as occasions for dialogue was therefore a key area of enquiry in this research. Participation in any group situation may evoke a wide range of responses. The experience may be positive or liberating for participants, but can also be experienced as stressful or threatening. If the setting feels too unsafe for participants to tolerate the degree of uncertainty that is a precondition for tolerating different perspectives, then the meeting is unlikely to be experienced as helpful (Mason 1993).

In the discussion that follows in this chapter this issue of the reception meetings as a potential forum for dialogue will be further considered by presenting data pertaining

specifically to the theme of voice, and by exploring the extent to which participants appeared to feel able to speak and to be heard by others in the reception meetings. The exploration of participants' accounts of their experiences regarding the meetings was a key aim of the study, particularly in relation to this theme of voice.

Stories about responding to uncertainty

The experience of entering a psychiatric hospital involves encountering a different and potentially unusual culture for the person concerned and also for their relatives or significant others. The service-user and family will therefore be involved in a process of assimilating or orientating themselves towards this new culture (Rose 1985), particularly during the first few days, which may be a period of high anxiety for all concerned (Scharfstein and Libbey 1982). One of the aims of the reception meetings was therefore that they would provide an opportunity for information sharing between the family and the staff; for the staff to inform the family about the organizational culture of the Unit and for the family, in turn, to inform the staff about themselves and their culture (Reed, Stevenson & Wilson 1998).

Attending the meetings in the first place might, however, be an anxiety provoking experience for all concerned, another step into the unknown at a time when all around was already experienced as strange. If the prospect of attending this kind of meeting generated too much anxiety or unsafe feelings, then little learning would be likely to occur (Mason 1993). On the other hand, it might be viewed as an important opportunity for service-users, staff and family members to talk together, an opportunity that can be surprisingly rare in psychiatric hospitals (Johnstone 2002). In this study I was therefore interested in exploring with participants what their initial feelings, expectations and preconceptions were regarding the reception meetings, as well as the extent to which these early impressions and expectations shaped subsequent experiences of meetings.

For many of the research participants, the reception meetings were a novel experience in that most had experience of attending a single meeting at the time when they were interviewed. These participants therefore had no prior direct experience which might guide their expectations about what would occur in the reception meeting. Similarly, most participants were likely to have had minimal discussion with staff about the meeting prior to

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attending. At the point when they were invited to attend, people were provided with an information leaflet which gave a short summary of the purpose of the meetings (see Appendix 2). Any prior discussions about the meetings tended to be kept brief, so that the agenda could be generated in the meeting itself, arising from the concerns of those who were present. This desire to engage in a less scripted form of discussion differentiated the reception meetings stylistically from the other meetings that occurred in the research site in that most meetings had a specific agenda and the discussion tended to be more instrumentally focused upon achieving particular outcomes. The looser style of discussion that occurred in the reception meetings therefore had the potential to generate a degree of uncertainty for participants, at least initially.

This experience of uncertainty was graphically expressed by Vicky, a service-user who had entered hospital on a voluntary basis. Although this was her third admission to the Unit, it was Vicky's first experience of attending a reception meeting:

Alex: I was wondering if it was on your mind before you went in (to the reception meeting), about what it was going to be like?

Vicky: I had no idea. I thought it was just going to be a meeting where you just said "Hello", and told my husband about why I was here, and what the hospital was like- visiting hours and things like that, so I was quite surprised when the conversation started off like that, but then it gave me the courage to speak, and it sort of got on to how I was feeling, and be able to let my father speak, and it sort of got round that way. I was very surprised, yeah. I was terrified before I went in! Absolutely terrified, because I didn't know what was going to happen! But once I was in, the first five minutes was just, eh... I didn't think about being nervous, because I had so much to say.

Vicky's initial frame of reference for the meeting was extremely hazy. She described having some expectation that it would be a introductory, information-sharing event, but at the same time, she also spoke of her initial feelings of *"terror"*, which suggested that she may have had an additional expectation that the conversation might shift into other, less safe or predictable territory. This lack of clarity about what to expect from the meeting might easily have produced a state of 'unsafe uncertainty' (Mason 1993), preventing her active participation in the meeting, or resulting in her having a negative experience of it. Vicky

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appears to have experienced the meeting as liberating, however. Her feeling of being a *"nervous wreck"* was dissipated when she used the reception meeting as an opportunity to talk with other members of the family about issues that they had not previously spoken about together, a process that she experienced as extremely helpful:

Vicky: I know that when I went into the meeting I was a bag of hammers (laughs). I was a nervous wreck, but when I came out I felt wonderful!

For Vicky the reception meeting provided an opportunity to speak openly about issues that had preoccupied her. Initial feelings of fear about what might occur in the reception meeting were also expressed by Maria, a service-user who had entered hospital for the first time:

Maria: I was frightened. I was anxious, I was very anxious, at the time, anyway, that I would be bombarded with questions, that I wouldn't be able to answer. Because I wasn't very good at the time, I feel better now.

These fears seem to have been largely abated for her when the meeting was underway, however:

Maria: It was entirely different from what I expected it to be. It brings things out in the open with your family, where sometimes you wouldn't say things, if you know what I mean? You wouldn't say things. But because it was like, in a meeting, you say more, I think.

While Maria's situation was different from that of Vicky in that she had not been admitted to a psychiatric hospital previously, the experience of attending a reception meeting was novel for both, along with associated feelings of uncertainty and apprehensiveness regarding what might occur. Despite these uncertainties, for both Maria and Vicky the meetings they attended also provided opportunities for speaking more openly about their concerns. Initial experiences of 'unsafe uncertainty' appear to have evolved into experiences of 'safe uncertainty' (Mason 1993), or at least 'safe-enough uncertainty', in the sense that the degree of apprehension and lack of clarity encountered didn't result in a loss of voice and prevent their participation in the meetings. Mason argues that a position of safe uncertainty is required for participants in a therapeutic conversation if dialogue is to occur: a position of 'unsafe uncertainty' results in participants feeling too threatened to participate dialogically,

whereas attempts to minimize the experience of risk through adopting a position of safe certainty results in a loss of curiosity and willingness to explore multiple perspectives. From the perspective of these service-users the reception meetings therefore appear to have represented both a site of potential opportunity for open talk, as well as an initial source of fear and apprehension.

Stories about locating a frame of reference

Faced with uncertainty about what might occur in the reception meetings, a number of participants spoke about drawing upon their previous experiences of other meetings or group situations in different contexts as a frame of reference to guide their actions in the reception meetings. Adam, speaking from a service-user position, described the apprehension about attending a reception meeting which his partner Sara experienced, and how she attempted to manage these feelings, (Sara had been unable to attend a research interview, but had shared her views with Adam and asked him to convey them to me). Sara, a teacher, had arrived late for Adam's reception meeting due to work commitments, so she missed the introductions that took place between the people who attended, possibly adding to her sense of uncertainty. Her feelings of apprehension were, according to Adam associated with several factors, including uncertainty about what might occur in the meeting; tensions in her relationship with Adam; and anxieties about his state of mind:

Adam: Because of the situation, between us, I think she was desperately trying to figure out what on earth was going on, because she didn't understand ... , ...She said she felt totally at sea. She did what she would normally do, professionally, I think...

Adam suggests that in the face of this uncertainty and worry, Sara drew upon her professional experience as a teacher to provide a frame of reference for how to act in the meeting. Using a framework that was familiar to her as a guide in this unfamiliar situation may therefore have been a way of managing the uncertainty associated with the meeting, so that she didn't feel overwhelmed by it.

A similar strategy of drawing upon previous professional experience as a point of reference was also adopted by Howard, a service-user who participated in the research. Howard, who like Sara had experience of teaching, had entered the Unit under the Mental Health Act

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(1983) in a very depressed and suspicious frame of mind. A reception meeting was arranged shortly afterwards that was also attended by his Mother, his primary nurse from the Unit, a CPN who was also a member of the reception meeting team and myself. Howard commented that the experience of meeting with an unfamiliar group might be *"daunting"* or *"off putting"* for many people in his situation, but also indicates that his previous professional experience as a teacher provided a helpful framework in this context:

Howard: It (the reception meeting) might be off-putting.

Alex: Yes, it might be. Was it for you?

Howard: Not this time, because I've got more used to these situations. Having done some teaching, I've got more used to having a group of people there.

For both Howard and Sara, drawing upon their previous professional experience in this way therefore provided them with a framework for participating in the meeting. Drawing upon these professional identities may have enabled these participants to connect with previous experiences within their lives of behaving competently and knowledgably within groups. Consequently, using their 'professional selves' as a frame of reference may have been helpful to them, initially, in creating distance from the feelings of anxiety associated with entering a forum where the implicit 'principles' or 'rules' guiding participation were not yet negotiated between participants.

Stories about staff expectations and uncertainties

Several of the staff who participated in the research also described feeling uncertain about what to expect from the reception meetings, and spoke about how they attempted to draw upon their previous experiences of attending other meetings in the service as a frame of reference. Jane, a social worker, discussed her initial expectations in relation to a reception meeting she attended for Marion, a service-user that she had been working with for some time. Marion had entered the Unit at a weekend, and so a reception meeting had been arranged at quite short notice on the Monday This was the first reception meeting that Jane had attended, so she had no prior experience to draw upon. In the following extract she

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indicates that in the absence of information about the reception meetings, her initial assumptions about what to expect were shaped by her experiences of attending other kinds of meeting in the service:

Jane: (I was told) only that it might be too short notice, but they were holding a meeting, and (pauses), just that Marion had been admitted on the Saturday, and it was a lot to do with the death of her father, and that was it. No information about the reception meeting. I think that I assumed it was going to be the same as a Care Programme Approach meeting, and.... (pauses) but she didn't say anything about the meeting itself.

Jane drew upon her previous experience of Care Programme Approach (CPA) meetings, which took place before a service-user was discharged from hospital, as a frame of reference for the reception meeting. Like reception meetings, CPA meetings occurring in the research site were also usually attended by the service-user and sometimes by their relatives, as well as members of the professional team. The CPA meetings tended to be more task-focused however, with the aim of devising and reviewing care-plans for the service-user, in contrast with the looser 'agenda' for reception meetings which were generally more process-orientated. Using the CPA meeting as a frame of reference in this way resulted in Jane feeling surprised by the amount of time that was spent in the reception meeting focusing on Marion's feelings. The unexpected turn that the meeting took evoked confusion for Jane about how she could participate in a useful way:

Jane: I was a little bit unclear about my role in the meeting. Then as the meeting progressed I was trying to work out if I was there as a support for Marion and Jim, or if I was there as Marion's key worker under CPA, and I felt like I sat back a bit in the meeting because I felt a bit unclear, and the meeting went along lines that... it wasn't what I expected.

Although Jane identifies some positive aspects of the reception meeting, the experience of uncertainty constrained her from participating as fully as she might have wished to. She had anticipated that the meeting would be used to attend to *"practicalities and things like that"* rather than on Marion's emotional distress. Despite Marion's entry to hospital occurring following the sudden and unexpected death of her father, Jane was surprised by the emotionally focused conversations that occurred in the reception meetings. The degree of surprise she experienced was linked with Jane's having had quite specific expectations of

the reception meeting, based on her experiences of previous meetings within psychiatric services. When the conversation in the reception meeting developed along lines she hadn't anticipated, Jane also experienced a related sense of confusion about her own position or role within the discussion.

Helen, another of the professionals who participated in the research also discussed her initial expectations regarding the reception meeting she attended. Like Jane, Helen used her previous experience of CPA meetings as a psychological reference point to orientate herself, but this appears to have been less problematic for her than it was for Jane, as she anticipated that the reception meeting would be different from, rather than the same as, a CPA meeting:

Helen: I didn't see it as a kind of agenda setting meeting or anything like that, I didn't see it as me being involved in any direct way, like a CPA meeting might, I saw it very much as a kind of introductory thing, "These are the people from the Ward, do you have any sort of problems?", that kind of thing. I saw it very much as a kind of a first step that might highlight some needs that we might look at after that, you know, perhaps in a different forum.

Helen seems to have appreciated the opportunity to engage in this less structured form of conversation. She does, however, describe experiencing some uncertainties in the meeting about what her role was and how she 'should' participate:

Helen: ...I think that one of my concerns, perhaps, was, I suppose I was full of... I don't know, I didn't really have an agenda, as such, and, I didn't really, I was more... I was inhibited perhaps in some ways, in that I didn't want to distract from Vicky or Jim's needs, and, you know, I suppose it's a case of, em, "Is this the right place for me to bring this up?" I can't even think of an issue that I was thinking of, but it's you know, "Is this the right time to check things out?".

Like Jane, Helen also seems to have been concerned in the meeting to try and work out the 'rules' for the conversation; rules about roles, how to participate, and what were the appropriate areas of discussion in that setting. The absence of a clear frame of reference for the reception meetings therefore seems to have been experienced as inhibiting for some professionals who participated in the study, leading to experiences of role confusion. This

process seems to have been more problematic for Jane than for Helen, in that Jane appears to have experienced the reception meeting she attended as rather frustrating, whereas Helen regarded the one she attended more positively. For Jane, the insufficient focus upon *"practicalities"*, coupled with the lack of clarity she experienced about roles in the meeting were perceived as important deficits, whereas Helen appears to have attended holding a looser set of assumptions about what should occur.

Previous research regarding psychiatric admissions units has suggested that staff and service-users have different areas of concern, with staff tending to be orientated towards medical model concerns over symptoms and medication whereas service-users are often preoccupied with more everyday matters such as companionship, housing, work, and so on (Sainsbury Centre for Mental Health 1998). This raises a question regarding the potential for a conflict of interests between staff and service-users in the reception meetings; that is, if the meetings had been organized in such a way that they were more congruent with the initial expectations of the professionals who were cited above, they may have been less likely to have provided opportunities for the service-users to voice their own concerns. An 'ideal' situation to have been achieved in the meetings might have been a 'both / and' position, where different, and sometimes contradictory accounts could be spoken about without any single perspective becoming elevated to 'truth' status (Andersen 1990). Such a balance is difficult to maintain in a contested social field like psychiatry, however, and the power differentials associated with disagreements about 'reality' are particularly resonant in hospital settings, where the staff who have a privileged voice also hold powers to impose 'treatments' against the wishes of the service-user. Again, a question is raised regarding the extent to which it is possible to create the conditions in which dialogue might occur in a meeting taking place in this kind of environment. At the risk of oversimplifying a complex situation, the reception meetings might be viewed as an attempt to introduce opportunities for dialogue between different social actors into an environment where monological forms of communication tended to prevail.

Stories about the reception meetings as a vehicle for enhancing connections

Relationships between members of the 'system of concern' which develops around a problem may become fragmented if there is no opportunity for people to meet and talk about

the problems and the meanings attributed to the service-user entering hospital. A number of the participants in the study identified the reception meetings as providing an opportunity to address this problem of fragmented communication and create greater connectedness between the different members of the family-professional system.

Helen, a CPN, discussed the importance of the reception meeting as a forum where people were brought together, and where the stresses created by the experience of hospital admission for service-users and families were acknowledged:

Helen: I thought it was a positive experience. Thinking about what should happen when someone goes into hospital, I don't think enough emphasis is placed on the stress that it can place on people, and their families, and I think just having something like that in place, you're acknowledging that it is difficult for people, and the very fact that the meetings exist is a good thing. And, I think my experience, yeah, it brought people together, that, for that particular client, and her father..., yeah, it brought them together.

Helen's comments about the positive nature of the meeting suggest that the people who attended the meeting were 'brought together' in a psychological sense, as well as physically. The reception meeting represented a form of acknowledgement, on the part of the hospital, of the stress experienced by the family. Similarly, Carl, another CPN, discussed his experience of a reception meeting he attended when Imogen, a service-user he had been working with for some time, was admitted to the Unit:

Carl: I think the thing that I liked about it really was the opportunity to get together...I guess an idea I have is that when people come into hospital, that often conversations are fragmented. I guess that often ward staff will meet with someone and have conversations, then I will meet with them, and then the person and their partner will have conversations, and there never seems to be an easy forum to come together and sort of share things, and I guess that I liked the idea that we could come together and talk about that admission.

Carl viewed the reception meeting as an important means of countering the fragmentation that takes place when conversations occur in different contexts and there is no forum for bringing these different strands of talk together. When a person enters hospital there is a particular danger of the voices of family members being ignored or marginalized because of

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the individually-orientated models which predominate within in-patient settings (Reed 1999), and Carl felt that the reception meeting played a particularly important role in addressing this issue by including Imogen's partner, Don, in the meeting:

Carl: Particularly, I thought it was important for Imogen's partner to be given an opportunity, because he'd been sat struggling with quite a lot of things, and it had been quite difficult for him to work out a way of helping Imogen, and I think it was quite good to allow them to come together and have a voice in things.

From Carl's perspective, the reception meeting was therefore particularly helpful in supporting Imogen's partner Don, who it seems had been feeling isolated and confused regarding what he might do to be of help. This emphasis on the value of the reception meetings as a forum for including family members and *"allowing them a voice"* was highlighted by several of the research participants. In view of the warnings from the previous literature regarding the potential for distant relationships between psychiatric staff and families to develop (Winefield & Burnett 1996), this was a particularly important feature of the meetings.

This theme of the reception meetings providing a forum for bringing people together was also highlighted by Mrs Conrad, when discussing the meeting she attended when her son Derek entered hospital. The reception meeting was attended by Derek himself, both of his parents, and staff from the hospital and community psychiatric team. Together with another member of the reception meeting team, I was also present to 'host' the discussion. At the beginning of the research interview, Mrs Conrad referred to the reception meeting as a *"welcoming meeting"*, and described it in very positive terms:

Mrs Conrad: The reception meeting was an excellent way of introducing the family to the management, in a welcoming, friendly and informal environment, which can only be beneficial to the patient, because he comes or she comes in (to hospital) very nervous, and often the parents do as well. I thought it was an excellent thing.

Scharfstein and Libbey (1982) have suggested that family-staff meetings within the first few days of hospital admission can be helpful to families in reducing the high levels of anxiety associated with this process. This view is supported by the comments of Mrs Conrad, who

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commented that the process of *"introducing everybody together"* that occurred in the reception meeting was particularly important in helping to allay some of these worries:

Mrs. Conrad: Oh yes, he (husband) was quite stressed. He has sleeping tablets now, but other than that he's all right. It's difficult to sleep, because you wake up thinking, worrying about when they're going to get better, if they're going to get better. All the things a parent goes through.... Yes, I think we were definitely glad we had been, just to see where he is and how concerned everybody was, and obviously the fact that you had a meeting shows that you were thinking about Derek and the right procedures, really.

The act of arranging a reception meeting was described by Mrs Conrad as an expression of concern by the staff, a gesture which seems to have been extremely supportive in the face of their intense parental worries about the situation.

Vicky, a service-user, also commented that the reception meeting was important in bringing people together and opening up communication between participants. In particular, Vicky felt that the reception meeting helped to bring about a stronger connection between her husband Jim and the staff:

Vicky: It helped me immensely. .... The first part was my husband being allowed to be there. In the past he's felt pushed out, and he didn't know what was going on here. He was confused, he was upset. Being able to come into the meeting, and listen to everyone, and hear what I had to say helped him immensely. It also helped me, because I was able to say things to Jim (husband) and my father with somebody being there. So that was very helpful. It gave me a little bit strength.

Vicky viewed the meeting as beneficial in two respects: for Vicky herself, it was empowering in that it offered a forum where she expressed her thoughts to her husband and her father in a way which had not previously felt possible. From a social constructionist perspective, the act of telling a previously unspoken story is an act of power (Pearce & Pearce 1998), and Vicky identifies this process as one of gaining strength. In addition, Vicky expressed the view that the meeting was beneficial for her partner, Jim, who had previously felt excluded:

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Vicky: Last time it happened, last time I was here, there was no reception meeting, and Jim obviously felt left out. He was disillusioned, he was upset. Basically, he didn't know what was happening, in terms of how I was and how I... I couldn't speak to people. Coming to the meeting, it reassured him, gave him a little bit of an insight into how I feel.

In this instance, the reception meeting appears to have provided a site where dialogue occurred; that is, where ideas and thoughts could be expressed more openly between family members, resulting in an enhanced understanding of the situation. The meeting also appears to have created, for Jim, an increased sense of connectedness with staff on the Unit:

Vicky: He thought it (the reception meeting) was a wonderful idea. From that meeting he has felt no qualms about coming onto the Ward, he's been able to come and speak to the nurses. Whereas last time I was in, he couldn't, he didn't. I don't know if he couldn't, but he just didn't.

Rose (1985) suggests that when a distant relationship between family members and psychiatric staff develops in the early phase of admission, this difficult relationship pattern frequently becomes amplified, rather than improving, over time. Vicky described graphically the degree of exclusion previously experienced by Jim during her previous admissions; a state of affairs that may well have continued and deteriorated if not for the reception meeting. Jim expressed a similarly positive view of the reception meeting, identifying it as an opportunity for Vicky to talk more openly with him:

Jim: I though it (the reception meeting) was informative- it certainly helped us. Because Vicky was saying things in front of me that she wouldn't, she hadn't said in the past.

As well as providing opportunities for more open discussion between Vicky and himself, Jim also felt that the reception meeting had brought him into closer contact with the staff in a way that he valued:

Jim: This is, that's the third time she's been in, and it's the first time I've sat down with anybody and talked about it.

The opportunity to speak with staff seems to have been an important development for Jim, as he referred to it several times during the research interview. Despite having some previous acquaintance with the Unit through Vicky's past admissions, he felt *"excluded"*, to use Vicky's term, in a way which also left him feeling upset, confused and disillusioned. It is important to emphasize that neither Jim nor Vicky suggested that these feelings of exclusion were prompted by unfriendly or overtly distancing behavior on the part of staff. Rather, it seems that the absence of a direct invitation from staff to participate was sufficient to deter Jim from approaching them regarding his concerns.

Helen, a CPN who had been working with Vicky for some time prior to the hospital admission, also regarded the process of 'bringing people together' in the reception meeting as particularly beneficial for Jim:

Helen: ...I knew there was a difficulty there. I knew that Vicky had said that she worried about her husband. Worried that (inaudible), so I thought that literally bringing him in, in that forum, might help to break the ice, and also acknowledge that he has needs here, he has concerns. Just having that forum there, that structure, might help that happen, more than, say, speaking to the nurses separately. And also, perhaps, it helped to break down some of the stigma, some of his worries about coming onto the Ward and speaking to people. Certainly, he's been involved in our meetings, so, he seems a bit happier about those things.

Helen's perception of the reception meeting was that it facilitated a *"bringing in"* of Jim, as well as of Vicky's father, David. This process led, Helen suggests, to a new openness and increased supportiveness subsequently:

Helen: Well I raised it (the reception meeting) the next time we met, just to ask how they felt about it, and they were positive about it, in that I think the significant thing for Vicky was that she was able to say some things, and Jim made a comment as well about his reaction, which was significant, something about his being defensive, which was in support of Vicky, because that's how Vicky felt. So that they were, in that way, able to support one another, he was able to share her reaction.

In creating a context in which people met together and shared stories that could not previously be spoken about directly, this reception meeting appears to have represented a

starting point for new developments in relationships between family members, and, particularly for Jim, in the relationships between family and staff. This new openness within relationships offered potential for change, since it is through the process of conversation between members of a system then new meanings are generated (Anderson 1997).

Stories about 'finding' a voice in the meetings

Receiving a diagnosis of 'mental illness' and entering a psychiatric hospital are experiences which can be profoundly disempowering for the individuals concerned, and may consequently result in difficulties in speaking confidently or authoritatively. A central aim of the research was therefore to explore the extent to which the reception meetings offered opportunities for people to gain an increased experience of voice by beginning to share their thoughts and concerns with others.

The perception of the reception meeting as a forum in which the service-user's voice was increased was expressed by Jane, a social worker. Jane commented on the effects of the reception meeting that was arranged for Marion, a long standing user of psychiatric services:

Jane: She (Marion) was certainly calmer after the meeting, she was able to, she'd opened up, from being sort of, from not looking at any one and not talking, not wanting to speak. You know at the start of that meeting she didn't want to speak, when the meeting finished she looked me in the eye, which she hadn't done and she started telling me things that she wanted to happen for her. Maybe that meeting had enabled her to do that afterwards?

Jane identified an important qualitative change that seemed to occur for Marion through the meeting. The reception meeting appeared to have been 'enabling' for Marion, helping her to find her voice. The distribution of power in the relationship between them altered in that Marion who previously appeared to be without voice began to look Jane in the eyes rather than averting her gaze, and expressed her wishes regarding what should happen.

Adam, a service-user, described the reception meeting as an opportunity to speak more openly about his 'inner' thoughts. Adam had been in hospital on previous occasions, but this

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was the first reception meeting that he had attended. The meeting was also attended by his parents and his partner Sara, as well as members of the professional network. At the beginning of the reception meeting Adam described feeling an intense sense of emotional turmoil, in response to which he found himself *"blurting out"* his thoughts and feelings in an attempt to gain some sense of relief:

Adam: ...I sort of blurted everything out, a sort of gush, and so I was sort of, then I was thinking....

Adam continued to describe this sense of urgency to discuss his thoughts and feelings that he experienced in the reception meeting:

Adam: ...I just wanted to, to... I wanted to, I wanted to... At the time, I wanted to let people know what was going on, I wanted to tell the truth. I had this thing that I had to tell people what I was really like, and get it out, just to relieve my own... how I was feeling.

The experience of *"blurting out"* thoughts in a group situation might potentially leave a person feeling unsafe, vulnerable or 'over exposed'. In this instance, however, the reception meeting appears to have been a cathartic experience for Adam, an opportunity to find some relief through expression of his inner thoughts and feelings. His account of the meeting also evokes the impression of a confessional, an occasion to *"tell the truth"* and reveal himself to the others present *"as he really was"*. Hoffman (2002) conceptualises the term 'catharsis' systemically, not simply as an outpouring of emotion, but as a sense of relatedness or community. For Adam, lost in his inner world of strange thoughts and worries about his relationship with Sara, this urgency to speak 'truthfully' may therefore have been associated with a wish to re-connect with others:

Adam: ...Somebody like myself who's been through services quite a number of times- I thought it (the reception meeting) was an opportunity to be truthful, to say exactly how I feel. And I think I have, its better, because you mesh...

Adam contrasts this experience of connection or of *"meshing"* with others in the reception meetings with his previous experiences of more traditionally orientated 'ward round' style meetings:

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Adam: The meetings I had in the past, it was much more 'Us and Them', it was like you sat in your individual place and would say what the problem was, it wasn't like...

For Adam, the reception meeting therefore appears to have provided a more empowering experience, a context where he could speak *"truthfully"* and gain a sense of connectedness with others. His account of attending previous meetings suggests that opportunities for speaking openly were minimal, with staff and service-users occupying roles that were narrowly defined.

The theme of the reception meeting as a site where the service-user began to give voice to their thoughts was repeated in an interview with Brenda, when discussing the reception meeting she attended after her son Nick was admitted to the Unit under the Mental Health Act (1983). Nick was a rather solitary, reserved young man, and Brenda describes how she was watching him carefully in the reception meeting to see whether he was able to participate in a beneficial way:

Brenda: When we walked in we sat down and got chatting and I was watching. I kept watching Nick's face all the time, I don't know whether you noticed, just to see his reaction, because he has very little... even on his body, his face, he shows nothing, but I kept watching, and I thought, "He's listening". So even though he doesn't give much back, he's taking it all in, and I thought "Well it can't do him any harm, because we're sitting there talking about him", and obviously he has talked about himself as well, which is really hard for Nick because he's never done that for a long time, and... But I feel as though when he did start to talk you get that little bit extra, even if it's only two conversations it's that little bit more out of him about how he's feeling.

Brenda appears to have found Nick's participation in the meeting encouraging. She observed him listening to what was being said, and beginning to voice his own thoughts. In doing so, he was breaking away from a longstanding pattern of not talking about himself.

For Brenda, an important dimension of the reception meeting was the extent to which it would provide an opportunity for her son to begin to talk about his situation with others and become more actively involved in the conversations that were occurring about his treatment.

Similarly, Maria, another family member who participated in the research spoke about observing her mother, Caroline, carefully in a reception meeting to see whether she spoke more openly regarding her thoughts and feelings. As with Brenda and her son Nick, Maria was concerned about how Caroline would experience the reception meeting; whether she would feel able to speak more openly about her fears and concerns, or whether she would feel too threatened and simply say what she felt others expected of her. In the following extract Maria discusses the difficulties that her mother has in expressing herself:

Maria: It's hard to understand my Mam, because for like sixteen years she's had certain things hammered into her, so I don't think she's been 100% honest, so I don't know if now when I say, "How do you feel, are you OK?", and she says, "Yeah".

Maria's primary concern in the reception meeting was whether or not it would be a useful experience for Caroline; that is, whether her mother who found speaking about her feelings so difficult would find her voice in this context. Because she was aware of the difficult life events that Caroline had experienced which have led her to feel disempowered and consequently so apprehensive about speaking out, Maria felt that Caroline's participation in the meeting was impressive:

Maria: I was just glad to get in there so that maybe my Mam might... to see how my Mam was more than anything else. I wasn't thinking about anything... how I would feel, it was more like, how my Mam was going to take it and stuff. But, I thought she did brilliant.

Caroline herself also described finding the reception meeting a context in which she felt able to speak more openly:

Caroline: It brings things out in the open with your family, where sometimes you wouldn't say things, if you know what I mean? You wouldn't say things. But because it was like, in a meeting, you say more, I think.

The reception meeting therefore seems to have been experienced by both Caroline and Maria as a safe, or safe enough, context to *"bring things out in the open"* with members of the family present. The comments from Maria, like those of Brenda cited earlier, highlight the extent to which family members constitute a network of concern in relation to their

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troubled relatives; both women described a similar experience in the reception meetings of maintaining an apprehensive vigilance over their relatives throughout the meeting in the hope that a process of 'opening up' would begin to occur. This data contrasts with Harbin's (1982) contention that family members tend to distance themselves emotionally from their hospitalized relative. Harbin argues that because psychiatric hospitalization usually occurs as a consequence of a crisis in which family relationships have becoming experienced as untenable, family members have a tendency to withdraw and 'hand over' their relative to the hospital. Data from Maria and Brenda, as well as other family members who participated in this study highlight the extreme concern that family members may continue to experience in this situation, however. It is possible that any emotional distancing that occurs is an unintentional consequence of a hospital culture which tends to be exclusively orientated towards individuals, rather than being based upon a wish by families to rid themselves of their relatives. Similar conclusions were drawn by Carpenter (2002) on the basis of a multi-site study which enquired about user and carer experiences of the Care Programme Approach. A majority (87%) of the carers who participated in Carpenter's study reported that they wished to be more involved in care planning, but only 39% felt that they had been encouraged by professionals to express an opinion. Only 20% of the service-users surveyed by Carpenter felt that their relatives views were heeded by professionals, although a majority said they wanted them involved. The barriers to greater partnership between families and staff therefore appear to be maintained by the individually-focused culture of psychiatry, rather than by the preferences of the families themselves.

Several of the participants in this study described the reception meetings as a forum where more open talk could occur between families and staff, where people who had hitherto found talking to be difficult for different reasons began to find a voice. From a social constructionist perspective this process of 'finding' a voice is deeply significant, since the phenomenon of voice and power are intertwined (Oliver 1996). A further feature of the reception meetings that was discussed by some of the participants was that discussions occurred without conflict breaking out between family members, and this theme will be explored in the section that follows.

Stories about coming together and making peace

A key aim of the research was to explore the extent to which the reception meetings offered a forum to participants in which dialogue could occur. In a hospital context there are many factors which potentially mitigate against dialogical communication, however, including the often fraught circumstances surrounding the admission process. People generally enter hospital at times of crisis (Moore 1998), when emotions are running high. At such times, relationships within families can become strained and increasingly polarised. Since dialogue entails a capacity to tolerate different perspectives, this might be particularly difficult for family members to engage in during this period. However, the data that will be presented in this section suggests that for several participants the reception meetings provided an opportunity for people to talk together without the conversation becoming overheated and breaking down.

Peter, a service-user in his late twenties who entered hospital under the Mental Health Act (1983) spoke about what he felt was the constructive conversation that occurred in the meeting that he attended. The relationship between Peter and his mother was under strain as a consequence of his recent erratic behaviour, as well as his open use of street drugs in the family home. During the research interview Peter's manner of expression occasionally seemed confused and was rather puzzling, but nonetheless he was able to discuss his experience of the reception meeting in a striking way, frequently employing powerful metaphors to express his point of view[1]. At the beginning of the research interview Peter described his general impressions of the reception meeting he attended in positive terms:

Peter: It was quite productive. In a word, productive.

Alex: What was it about the meeting that gave you that sense?

Peter: I can't really say, it was just a sense I got, an impression, by the end when I came out. It was a sense of productiveness, from the start to when it ended... at the end there was

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[1] Seikkula (discussed in Penn 1999) proposes that metaphor is often employed as a means of expression by people identified as 'mentally ill' when other, more conventional styles of communication have become difficult to engage in. Metaphor is a 'marginal' form of communication, according to Penn (1999) which is simultaneously ambiguous but also powerfully expressive.

a sense of being satisfied, of having completed something, some wheels had been set in motion.

Peter went on to make a connection between this sense of the meeting having been *"satisfying"* and *"productive"* with the way in which he felt it brought people together:

Peter: By the end of it I thought, "Well, that's been a conclusive sort of meeting, there was some conclusions reached about...", there was just a sense of communion there, everyone had a say, as far as I can remember, everyone had an opinion.

This sense of *"communion"*, of *"everyone having an opinion"* seems to have been particularly important for Peter, as it contrasts with previous argumentative discussions within the family about his lifestyle. The reception meeting provided an opportunity to *"have a reasonable discussion, an exchange of views"*, without relationships becoming polarized. According to Saukko (2002) dialogue entails an encounter between people in which multiple, sometimes contradictory accounts can be explored without participants retreating towards simplistic judgmental positions. It might therefore be said that for Peter, the conversations that occurred in the reception meeting were dialogical in nature, in that the different people present were able to speak and be heard, each expressing *"an opinion"* without any single perspective dominating, and without participants engaging in 'reality disagreements' (Birch, personal communication 1992). From a social constructionist perspective it is through dialogue that new meanings are generated (Anderson 1997), and for Peter the experience of the reception meeting was associated with a sense of productivity and forward motion.

Another of the research participants, Christine, also spoke about the reception meeting as a place where the family could talk about matters that had previously been difficult to discuss. Christine was in her early twenties and was admitted to the Unit under the Mental Health Act (1983). In the research interview she describes the difficulties that she previously experienced in talking with her family, and in feeling that what she was saying was taken seriously by them. Relationships within the family were therefore fraught, and Christine says that she initially intended to have an argument with her relatives in the reception meeting:

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Christine: I had every intention of going in there and causing World War Three! Really, I did! I was going to play holy hell with my husband and I was going to play holy hell with my father..., ... I went in there with bad intentions, and then I sat down and thought, "No, that's not right". So I went in there to make peace, you know? And I'm glad that I had the right people around me to help me make peace.

The reception meeting provided a forum for Christine to talk differently with her family; a place where they could talk in a less angry or polarised manner. For both Christine and Peter, the reception meetings they attended provided opportunities to stand aside from the family conflicts they had previously been immersed in and engage in calmer talk with the family. Colgan McCarthy and O'Reilly Byrne (1995) have discussed the importance of creating a social and linguistic domain in systemic meetings in which diverse and contrasting accounts can be expressed, and in which ambivalence and ambiguities can be tolerated by those who are present. From this perspective, the 'making peace' that occurs through dialogue does not entail all participants agreeing on a single, uncontentious account of the situation, but rather, a toleration of difference without the conversation breaking down. Peter, for instance, described the reception meeting he attended as an experience of *"communion"* in which *"everyone had an opinion"*, rather than a process whereby all participants voiced agreement regarding the veracity of a single opinion.

Stories about difference and potential conflict

While a number of participants in this research spoke positively about their experience of participating in network meetings and felt that opportunities were opened up for themselves or others to speak more openly, some participants also described the group format of the meetings as inhibiting, at least in relation to certain topics of conversation. A fear regarding raising issues that were important but also potentially contentious, for instance, was one of the factors identified by some who took part in the research as constraining them from speaking at times in the reception meetings.

Stories about potential conflict between family members

The presence of different family members at the reception meetings may provide opportunities for new stories to be shared, but may also be experienced as threatening if there is overt or latent conflict between them. Harbin (1982) suggests that such interpersonal tensions are not uncommon at the point where a person enters hospital, since the reason that hospitalisation occurs in the first place is often that the situation at home has become untenable. A further, associated area of dispute within families may centre around how long the service-user should remain in hospital, with the person who has been admitted, their relatives, and the staff often having differing points of view. Family tensions in relation to this latter issue were identified as a potentially inhibiting factor by Mrs Conrad, who attended a reception meeting after her son Derek was admitted to the Unit under the Mental Health Act (1983). While generally she talked about the reception meeting that she attended in extremely positive terms, Mrs Conrad also commented on the difficulties for relatives of speaking openly where potentially fraught topics are concerned:

Mrs Conrad: I think that this is a big point in psychiatry. ...Everything should be for the benefit of the patient, but sometimes if the patient's there you can't always say what you want to say, in case you offend the patient. That didn't happen when we met, but that is a point, I think, that's got to be viewed and discussed. I mean, for an example, if the patient wants to leave sooner than the parent thinks..., the parents put up against the patient, and this is not very good... this is not very good, eh..

In suggesting that the presence of the *"patient"* might deter relatives from raising sensitive issues for discussion, Mrs Conrad was speaking in general terms about how matters of confidentiality are managed in psychiatry, adding, *"that didn't happen when we met, but that is a point, I think, that's got to be viewed and discussed"*. This appeared to be a particularly important area of concern for her, however, as she returned to the issue again at the end of the research interview:

Mrs Conrad: Then again, we go back to talking in front of the patient, you know, from a parent's point of view, if the patient could have perhaps gone out at the end, so that if there's anything... but I understand that this is a difficult situation, because he is an adult, and adults don't like to be talked about, particularly if they're not well, I imagine. So this is

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the dilemma that a lot of parents are in with psychiatry. Not really, because I did ask you in front of Derek, I hesitated..., but that's the only thing- always discussing things in front of them . But it can't be helped really, because they have a right to their privacy too. An awkward situation, because they have a right, I suppose to their privacy, if they're over 21 definitely.

Mrs Conrad appeared to be trying to reconcile two conflicting positions here: a wish to talk privately with staff regarding her concerns about her son, balanced against an appreciation of the rights to privacy and confidentiality of a person of adult age.

Similar concerns about talking openly in the presence of other family members were expressed by Caroline, when discussing the reception meeting she attended after her mother, Maria, entered hospital. Caroline described feeling acutely conscious of the presence of her brother in the meeting, and of the potential for conflict to occur because of their different views about Maria's situation:

Caroline: There is another point which, now I'm thinking, with these meetings, is maybe not two people who are part of the family (meeting together)... because me and my brother want the same thing, but we've got different views a bit, and I think that we could probably end up arguing. Because what one says, the other one might agree with a little bit, but not totally, and then you'd be... I was dying to say, "Well, hold on... ", and some of the things that I had said, I could see that he wasn't happy about. So I think that maybe, not to many of the immediate family, just one of the immediate family, but at different times. Well say it's a person with three kids, one time one of them go in, the next time another, the next time the next one. Because I think also, you tell people different things anyway, don't you?

This wish to avoid topics of discussion that might lead to disagreement between family members seems to have been an inhibiting factor for Caroline, leading her to be selective about the topics she discussed. In the reception meeting, for instance, Caroline had suggested that one of her mother's major fears about entering hospital was that she would be kept *"in here for life"*. Caroline later said that she regretted raising this topic, in case her brother felt that it was an inappropriate area of conversation that might further alarm their mother:

Caroline: When I said, "My Mam thinks she's in here for life. I thought, "OOPS, I probably shouldn't have said that", because I think that she did think that. I was just saying it, like in banter, but after I did say it, it was like.... my brother sort of looked at me... (pause). ...he gave me a funny look, and I sort of looked and thought, "Maybe I shouldn't have said that".

Openly discussing issues that are sources of worry, such as whether the service-user will be *"kept here for life"* might be viewed as an effective means of dis-spelling these powerful ideas and providing reassurance. A number of factors might potentially inhibit families from voicing their concerns openly in this way, however. Feelings of protectiveness towards the person in hospital may deter people from raising potentially upsetting topics, for instance, along with a desire to avoid arguments or accusations of disloyalty from the service-user if the relatives think the person should stay in hospital for a longer period than the person wishes to.

Despite the reservations expressed by Caroline and Mrs Conrad regarding the experience of being invited to discuss their concerns in the open setting of the reception meeting, both of these participants also described the meetings they attended in generally positive terms, describing them as beneficial both to themselves and to their hospitalised relatives. This suggests that, for some families, there is a tension associated with participating in network meetings. On the one hand the group context of the meetings is anxiety provoking and raises fears about the potential for conflict or distress to be evoked, while on the other hand it is the very experience of talking openly which is in itself potentially liberating. Thoughts and feelings which have not previously been openly expressed can begin to be voiced and heard, lifting a weight of silence. Caroline, in particular, recognized the therapeutic dimension of talk, and was eager that her mother would break a longstanding pattern of suppressing her own voice, and begin to talk about her feelings in the reception meeting.

Within the field of systemic practice a number of authors have commented upon the dangers of the therapist engaging individual family members in conversation, especially if these conversations occur in 'secret' from the rest of the family (Selvini Palazzoli & Prata 1982; Carpenter & Treacher 1989). These secret conversations will inevitably have an influence upon other patterns of communication within the system. Writing from the field of adult psychiatry, Scott (1973; 1995) warns that conversations of this nature may exacerbate processes of interpersonal 'closure' between the family and the service-user by reinforcing

the view of the service-user as lacking in 'insight' and unable to accept adult responsibilities or participate in the discussion 'appropriately'. Since one of the broad aims of the reception meetings was to counter the process of 'closure' (Reed 1999), the views of Mrs. Conrad and Caroline represent something of a challenge to one of the guiding principles for the reception meetings; that is, that the discussions should occur openly with the members of the 'system of significance' present.

Gender may also have been an important factor influencing the ways to which the research participants experienced the group context of the reception meetings. The participants who expressed the greatest reservations regarding this aspect of the meetings were women who appeared to be apprehensive about speaking openly in the presence of their male relatives. Gender is crucial in shaping how power is distributed within families and other human systems, and can be a significant factor influencing the extent to which individuals may feel able to voice their inner dialogues in relationships with others (Brown & Gilligan 1992). Our individuals 'inner worlds' and the conversations that we have privately, with ourselves, are inevitably infused with and shaped by dominant societal narratives regarding gender. Watkins (1999, p. 254-255) states:

"Yet in the most private of the dialogues in our dreams and fantasies, in the most intimate portions of our conversations with ourselves, we come upon the metabolization of culture, economics and politics. In the structure of power between ourselves and other voices of thought, we can see ... the imbalances arising from such things as racism and sexism...."

These gendered subjective experiences of self and others in turn impact upon our experiences of voice and authority within social encounters. Brown and Gilligan (1992) argue that learning to suppress one's own voice is part of the developmental experience of young women in Western societies. Because of the imbalances in power relationships between men and women in our society, gender may therefore be an important factor influencing how invitations to engage in open dialogue in a group setting such as the reception meetings are experienced. If one has been socialized into not openly 'speaking our minds', then the invitation to do so may be received with uneasiness.

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Stories about difference and potential conflict between staff and service-users

The experience of being invited to speak openly in the reception meetings with the service-users and family members present may also have been inhibiting for some professionals, since a professional culture of secrecy frequently prevails in psychiatry where staff tending to discuss their opinions about the service-user behind closed office doors (Andrews et al. 2000; Furman & Ahola 1992). On a number of occasions professionals who participated in reception meetings seemed to have doubts about the accuracy of comments made by service-users, but felt it inappropriate to disagree by offering an alternative, contradictory account in the group setting. This dilemma is discussed by Jane, a social worker, in relation to the reception meeting she attended for Marion who had recently entered the Unit:

Jane: I think she (Marion) actually... I mean, I know that she was very distressed, but I think she actually likes meetings, she likes appointments, she... I know that it might sound an awful thing to say, but she sometimes plays up to these meetings. I often accompany Marion to out-patient appointments and she presents completely differently from sitting in the waiting room with me to going in and talking to the consultant psychiatrist, it's like... she's got to be looking and presenting as very, very ill, and crying a lot. And I think that people in the room obviously didn't know her, you weren't aware of that, you know, and also, some of the things that she was saying, there was a little bit of a slant on them, and... I thought that it's not really the right time for me to step in and say, "Well actually, this sometimes happens", and I felt that there was a lot of background to it that yourself and some of the nurses perhaps weren't aware of, and I didn't feel it was the right arena for me to step in and contradict Marion in front of new people to her... and also, whether or not you had a right to know, as well, you know? I think she was serious in what she told you, I didn't think that she was telling you the whole picture.

Marion is considered by Jane to be an unreliable narrator whose way of talking needs to be managed by the professionals who are involved, if the *"whole picture"* is to be understood. Jane's reluctance to publicly contradict Marion in the reception meeting was presumably based on feelings of protectiveness or a wish to avoid open disagreement. At the same time, remaining quiet about this conflicted for Jane with her belief that the staff team had a *"right to know"* the reality of the situation, as she perceived it.

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A similar example of professional concern about the veracity of the service-users account was recorded in journal notes I made following a reception meeting for Hassina, a young Bangladeshi woman admitted to the Unit under the Mental Health Act (1983). The following people were present at this meeting: Hassina's parents; Sharon, an adult education teacher who had close involvement with Hassina and her family; an interpreter; a member of the hospital nursing team; and also three members of the reception meeting team, (including myself). Hassina herself had decided not to attend at the last moment, but it was agreed by the others present that the meeting should proceed. Immediately after the reception meeting I made the following note in my research diary regarding processes that I had observed in the session

Sharon was writing notes during the reception meeting, (although this had not been discussed or negotiated). These notes which were disagreeing with comments made by the family were passed by Sharon to Glenda (a member of the reception meeting team) for her to read in the meeting.

Rather than openly expressing disagreement with the comments made by the family, Sharon communicates this in a more covert manner. In the meeting she was invited by a member of the reception meeting team to voice her concerns more directly, but Sharon appeared to experience this invitation as inappropriate, because she requested to speak to a member of the reception meeting team outside of the presence of the family prior to a subsequent meeting. For some professionals, the invitation to share their point of view openly in the reception meeting might therefore be experienced as 'too unusual' (Andersen 1992), by comparison with the professional practices that are more familiar to them. As well as the relative strangeness of speaking openly about their views in a setting where the service-user and family members are present, there are several other factors which may inhibit professionals from participating in this way. Community-based professionals such as Jane and Sharon might continue to meet with the service-user over a lengthy period of time, long after discharge from the more custodial hospital environment has occurred. These professionals may therefore be reluctant to openly express contentious views that might jeopardise their ongoing relationships with the service-user and family. This is a dilemma which parallels the inhibitions that relatives may feel about speaking freely in the presence of the service-user, as discussed by Mrs Conrad earlier.

A further factor which may inhibit professionals from voicing their ideas openly in a group forum such as a reception meeting is the differing status of their narrative accounts, relative to those of the service-user and family members. In a psychiatric context, professional narratives are more likely to be regarded as authoritative statements of 'truth' while the stories told by service-users and family members may be viewed as less reliable or insightful. A professional who is asked what they think in a reception meeting may hear this not so much as an invitation to express a point of view, one amongst many, but as a request to describe the situation 'as it really is'. When the professional holds a belief that is counter to that of the service-user, this is not likely then to be experienced as a matter of voicing difference in a postmodern realm of multiple realities, but rather as the professional correcting the flawed perspective of the service-user. This dilemma may have been experienced by Jane in the tension she described between not wishing to contradict Marion openly, but also feeling that the rest of the professional team should know the *"full picture"*.

Alternatively, professional discomfort with the process of speaking openly may have been associated with a potential loss of authority. As Furman and Ahola (1992) have argued, the conversations that traditionally occur between staff outside of the presence of the service-user have the effect of maintaining the power differential between the two groups. Similarly, Andrews et al. (2000) have referred to these staff discussions that occur behind closed doors as a form of professional 'gossip' which maintain distance and hierarchy. Both Jane and Sharon subsequently attempted to make contact with the other staff who had been involved in the reception meetings to gather further information or to clarify the veracity of what had been said. This may therefore have been a means by the professionals concerned of regaining a sense of authority by restoring the more traditional conversational boundaries that are operational in psychiatric settings.

At times the practice of speaking openly in the service-users presence might also have been perceived as mitigating against staff fulfilling a key professional function: the assessment of the service-user's 'mental state'. Service-users are frequently admitted to psychiatric hospital to be 'assessed' in a safe environment, a procedure which entails staff developing an account of the nature of the issues that the service-user presents with. This includes a formulation of whether the person's difficulties are 'psychiatric' in nature or not. There are times when the formulation developed by staff may be a source of contention, for instance,

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when the staff view the service-user as 'ill' and the service-user disagrees, or visa-versa. Discussions between service-users, families and professionals around this topic can therefore become complicated and fraught, as the formulation that is developed by staff has consequences for the further treatment of the service-user (Scott 1973). Decisions about whether a person remains in hospital or not, for instance, centre around an assessment of whether or not they are 'mentally ill'. Individual members of staff might be reticent about sharing their view about this issue in open setting, if they feel that what they wish to say is not likely to be well received by the others who are present. This dilemma is highlighted in the following field notes that I made subsequent to a reception meeting:

Reception meeting attended by a male service-user in hospital for the first time, his partner, their baby daughter, and his mother. The primary nurse was Julian, and Dennis (CPN and member of the reception meeting team) and I hosted the meeting. The discussion in this meeting was focused upon the extreme harassment that the service-user and his family have faced as a consequence of involvement with local villains who he has crossed in some way. The service-user was emphasizing that the situation would be easier if he was dead, and also talked about feeling violent towards the people who were threatening his family. The family were very relieved that he was in hospital, and were keen for him to remain so.

After the meeting there was some discussion between Dennis, Julian and I. Julian commented that the service-user was being discharged tomorrow, but that he had not been informed of this yet. We then had a lengthy discussion about whether or not the problem was 'psychiatric' in nature, and whether the client was 'putting on an act' in order to stay in hospital away from trouble.

In this situation the medical and nursing team had reached the conclusion that the service-user was not genuinely 'ill' and shouldn't be allowed to use the hospital as a refuge from criminal activity. Dennis and I were, like the service-user and family, unaware that this decision had been reached prior to the reception meeting commencing. Julian, who was privy to the information, was perhaps understandably reluctant to reveal this in a context where he might have to contend with the responses of an enraged service-user and family.

If a professional is unable to voice their views openly in a reception meeting, however, this may undermine their confidence in the value of the discussion that occurred and the quality

of the information that is exchanged. Jane, for instance, expressed ambivalent feelings about the reception meeting she attended in our research interview, commenting subsequently, *"I felt that afterwards, from my point of view, I hadn't got the information that I needed"*. Similarly, Sharon's actions in the reception meeting suggest that she held views about the situation that were in marked contrast with those expressed by the family, but felt that it would be inappropriate to air these differences in a group context.

Summary

This discussion in this chapter examined participants' accounts of their experiences in the reception meetings, particularly their experiences of voice and dialogue, that were central to the overall aims of the study. Several participants spoke about the reception meetings as providing an important opportunity for the service-user, family members and staff to meet together at a time of enormous stress. Participants identified a number of potential benefits associated with this process of meeting together:

- For some, the act of convening a meeting was in itself a way of staff providing reassurance to families by signaling their interest and concern.
- The meetings brought together the otherwise fragmented network of conversations which occur within the family and professional 'system of concern' which surrounds a person at the point of hospitalization
- Opportunities were created for speaking about important issues which have been previously been unsaid. From a social constructionist perspective, the processes of communication through which 'stories lived' become 'stories told' may in itself be empowering for participants (Pearce & Pearce 1998).
- The distancing between relatives and hospital staff which occurs as a consequence of individually-focused hospital procedures and culture may be bridged.

Data presented in this section also suggests that the invitation to speak openly and more personally in a social network meeting may also be experienced as unusual and potentially threatening, however. Several participants who spoke positively about their experiences in the reception meetings also identified the group context as potentially inhibiting. Power differentials between professionals, family members and service-users might generate

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inhibitions, for instance, as might latent conflicts within families. Similarly, gender is a significant context which might influence the extent to which participants feel able to speak authoritatively in such a setting.

The dimensions of the reception meetings that were identified within this chapter as potentially stifling to dialogue carry important practice implications, since staff who are hosting or facilitating network meetings in a psychiatric context will need to be mindful of potential sources of constraint. Lack of sensitivity towards these potential areas of constraint may result in a state of affairs where genuine dialogue doesn't occur. Vuokila-Oikkonen, Janhonen and Nikkonen (2002) have warned that the conversations within network meetings may become over-focused upon the concerns of the professionals who are facilitating them if the professionals concerned do not take particular care to attend to cues and signals from participants regarding other potential areas of conversation that they may wish to pursue. In the chapter that follows, data which carries direct practice implications for staff working in this field will be presented and discussed.

Chapter 10. Postmodern practice and the reception meetings: the co-creation of opportunities for dialogue

Practice development is a primary focus within practitioner research (Reed & Procter 1995), and a key concern within this study was the exploration of practice issues with the aim of highlighting possibilities for future development. At the same time, aspirations towards developing rigidly prescriptive recommendations or a specific template for 'good practice' would be inconsistent with a postmodern emphasis upon diversity and the uniqueness of specific contexts and circumstances. In this section I therefore focus on exploring data regarding the participation of the reception meeting team in the meetings with the aim of 'thickening descriptions' of the kinds of activities by team members that was perceived as helpful by participants. My aspiration is to suggest and explore different practice possibilities that may be stimulating to others in the mental health field who wish to work more collaboratively with service-users and their social networks, rather than to extrapolate generalized principles and guidelines for practitioners to adhere to.

The demise of the 'Expert' in postmodern practice

The Finnish Open Dialogue approach (Seikkula, Alakare & Aaltonen 2001) which provided inspiration for the reception meeting team is strongly influenced by postmodern thinking. It is therefore useful to briefly consider some of the issues and tensions associated with postmodern approaches to mental health practice, prior to presenting data from this study which explicitly addresses practice concerns.

A modernist understanding that there is a directly accessible objective reality which can be predictably influenced or manipulated through technological means has been the focus of critique by several practitioners influenced by postmodern ideas (Anderson 1997; Hoffman 2002). The conception of psychotherapy, for instance, as a hierarchical relationship in which the service-user is treated by a professional 'Expert' who skilfully applies a range of techniques which remove the problem is replaced by the metaphor of therapy as a collaborative conversation. This conversational metaphor implies relationship patterns between professionals and families that are heterarchical, rather than hierarchical in nature (Andersen 1993a). The service-user, family members and

professional team each bring their own unique experiences and understandings, and it is the service-user and family, rather than the professionals, who are viewed as the 'Experts' on their own lives and relationships (Anderson & Goolishian 1992).

In the field of systemic practice and therapy this postmodern idea of the therapist as 'non-Expert' has been controversial, however. Mason (2002), for instance, argues that the idea of the non- Expert, 'not knowing' practitioner has been taken over literally by some within the field, citing Derrida's observation that *"not knowing does not mean that we know nothing"* (in Mason 2002, p. 49). Mason instead argues for a position of *"authoritative doubt"* in which the pursuit of premature certainty is laid aside, but in which the practitioner participates skilfully in a collaborative conversation, drawing upon their own professional and personal knowledge and abilities. Similarly, Harlene Anderson, an author who is strongly identified with the development of the non-Expert position in the family therapy field comments:

"The approach does not rely on preconceived knowledge such as commonalities of problems or on across-the-board skills and techniques. This does not mean that "anything goes" or that this conversational therapeutic process unfolds simply by maintaining an atmosphere of nondirective and empathic conversation. ...Nor does it mean that therapists do not know anything and enter the room as a tabula rasa; quite naturally, they bring with them who they are and what that entails. It means the therapist's pre-experiences and pre-knowledges do not lead. In this process both the therapist's and the client's expertise are engaged to dissolve the problem". (Anderson 1993, p. 325).

Tensions between a collaborative postmodern approach as described by Anderson and a modernist conception of the professional 'Expert' may be particularly apparent in hospital settings such as the site for this study. People enter hospital to receive intensive help that is not otherwise available to them, and expectations may therefore raised regarding the specialist interventions that will be received. Staff working in these contexts therefore frequently experience particular sets of expectations that position them as 'knowing' professionals who hold specialist technical expertise with which they can remove pathology (Reed 1999).

Practitioners in the reception meeting team attempted to find ways of relating to the others who were present in the meetings which were collaborative and heterarchical rather than monological and impositional, despite the potentials barriers to this which

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were associated with the organizational setting. One of the principles of systemic theory is that there is not always congruence between our intentions in acting in a particular way and how our actions are perceived by others, however (Tomm 1987). In other words, it is possible for practitioners to act with the intent of facilitating dialogue and for their actions to be experienced as impositional, (and, conceivably, visa versa). In the discussion that follows the stories told by research participants regarding the practice of the reception meeting team in the meetings will therefore be explored, to generate an account of what kinds of participation were experienced as helpful or facilitative. The practice of team members, as it was perceived and described by the research participants, will also be discussed in relation to key themes from the postmodern systemic practice literature.

Stories about team members presence and manner in the reception meetings

The experience of attending a meeting where several people are present is potentially anxiety provoking for service-users and families, as was highlighted by data presented in the previous chapter. This may be particularly so when the professionals who are present are unknown to the family. Under such circumstances, service-users and family members might be wary of speaking openly, particularly if they are uncertain regarding how their comments might be interpreted by the professionals who are present. Maria, one of the family members in the research described being acutely aware of the actions of the staff members who were present at the reception meeting she attended when her mother entered hospital. In a research interview Maria discussed an assumption she made that the staff were attempting to psychologically analyse the family in the meeting. At this point in the reception meeting Maria therefore experienced the professionals who were present as adopting a detached 'observer position', and so she in turn engaged in a cyclical process of observation, in which she watched the staff watching her:

Maria: You see, while we were talking, I was watching everyone else. I was thinking, "they're trying to suss me out!". I was wondering if you were trying to see our reactions or anything, which obviously you probably were, but it was, I dunno.... ...As soon as I was finished speaking I was looking at them, and that... I was thinking... (long pause). I was worried in case I said the wrong thing- for whatever reason, I don't know.

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Although Maria initially stated that that this feeling of being analysed didn't stop her from speaking her mind, she subsequently contradicted this when commenting on her anxiety in the meeting about saying *"the wrong thing"*. Her experience of the staff as detached observers suggests that the encounter was at that point monological in nature. That is, Maria experiencing the staff concerned as relating to the family from an 'I-It' position rather than a dialogical 'I-Thou' position (Buber 2000). From this objectified position, Maria experienced hesitancy about speaking openly. Over the course of the reception meeting, however, this experience of inhibition appears to have softened for Maria, as later in the research interview she spoke about having experienced opportunities for more open speaking and hearing.

Maria's description of experiencing staff within the reception meetings as detached analytic observers differs from the other accounts within the data-set for this study. Most participants spoke about the professionals who participated in the meetings as adopting a more informal, conversational approach. Caroline, Maria's mother, commented that the members of the reception meeting team who participated in the meeting she attended approached the conversation in a non-intrusive manner which helped her to feel more relaxed about speaking:

Caroline: Sometimes it's hard to talk. It is, I find it hard (pause). But I wasn't uneasy.

Alex: Was there anything in particular that helped you to talk?

Caroline: I felt relaxed. I think just the people- the way that they were. Not... (pauses) Not like I expected it to be with... (pauses) going at you- I expected loads of questions that made me feel anxious and not know what to say at all.

Caroline anticipated that the team members who hosted the discussion might behave in a rather persecutory manner and interrogate her with questions in the meeting. The adoption of a more gentle pace for the conversation by the team appears to have contributed to the creation of a sufficient sense of safety for her to give voice to her inner thoughts.

Similarly, Marion, another of the service-users who participated in the study suggested that the conversational manner of the staff allowed her to express her thoughts and feelings in relation to a recent painful loss:

Marion: I experienced it as, that they (the team) talked to me. You know, I was... I can't say it straight... I felt right there.

Alex: Did you, yes? You showed a lot of tears, and you were upset in the meeting...

Marion: I lost my Dad, you see. It gave me a chance to talk with someone and tell them how I felt.

It appears that Marion experienced difficulty in articulating precisely what aspects of the manner in which team members approached the conversation were helpful to her, but identified a sense of experiencing herself as being in the *"right"* place at the reception meeting to speak about her loss. According to Hill and Michael (1996), skilful mental health practice is often 'invisible' in the sense that it is unobtrusive and has a quality of 'ordinariness'. This is not to say, however, that craft or expertise is not required. The situation is akin to that where an experienced musician performs a complex piece in a way that gives an appearance of simplicity and effortlessness. Shotter (1993) identifies a similar type of ability which he terms 'knowing of the third kind'. This form of knowledge relates to how to position oneself in relationships in order to open up conversational opportunities rather than to academic knowledge or technical expertise. As well as being 'invisible' in the sense of being unobtrusive, this 'knowledge of the third kind' can also be difficult to describe very precisely or to teach in a conventional way (Hoffman 1993). The promotion of postmodern practice approaches which may evade precise description is a potentially difficult endeavour within a service-culture where there is a preoccupation with standardization and audit.

A gentle and informal approach to the conversation was also identified by Mrs. Conrad as characteristic of the way that staff participated in the reception meeting that occurred when her son entered the Unit:

Mrs Conrad: "I also thought that the management gave the required information about procedures in the hospital to the patient, but then once again in a nice quiet, informal manner, and.... the parents can also ask questions about the hospital"

Experience of the professionals in the meeting as *"quiet"* and *"informal"* in manner appears to have been important for Mrs. Conrad in creating a context where questions could be asked and an exchange of information should occur. Interestingly, Mrs Conrad herself employed a very formal style of communication in the research interview,

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adopting a more distant, third person position to express her views. Informality as a quality that the reception meeting team brought to the meetings therefore appears to have been valued by participants with diverse personal styles of communication, rather than solely by those who were themselves informal in manner.

This emphasis on the value of professionals adopting a more 'informal', 'relaxed' 'quiet' approach as a means of creating conversational space for issues of importance to the service-user and family members to be explored echoes themes which have been developed within the postmodern family therapy literature. Hoffman (2002), for instance, discusses the development of a more 'subjective' approach to practice which is more conversational, more 'ordinary' and less instrumental in style. Similarly, Anderson (2001) draws comparisons between postmodern family therapy and the person-centred approach to counselling developed by Carl Rogers, which is characterized by a less active or technological stance by the therapist. Within Rogerian counselling, the emphasis is placed upon the quality of the relationship with the service-user, and upon respectful listening by the counsellor[1].

Stories about widening the circle of the expressed

Writing from a postmodern perspective, the family therapists Goolishian and Winderman (1988) argue that the role of the therapist is to assist in elaborating new narratives in relation to the dilemmas which have led to people seeking help. These authors cite a phrase from Hans Lipps that any linguistic account carries with it a "circle of the unexpressed" (Goolishian & Winderman 1988, p.141). Through conversation and dialogue the previously unspoken about experiences find language and expression:

"...all linguistic communication carries within it an infinite resource of possible new expression and meaning. Thus the content of all dialogue is open to change. Therapy is an activity which expands and elaborates upon the unsaid". (p. 141, original emphasis).

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[1] While the emphasis that Rogers placed upon the personal qualities of the therapist and the importance of the therapeutic relationship mirrors recent descriptions within the postmodern therapy literature, there are also important differences between these approaches. The work of Rogers was located primarily in a humanistic tradition and was focused upon working with individuals, in contrast with a social constructionist orientation towards 'persons in relationship' (Anderson 2001).

Seikkula and his colleagues similarly conceive of their Open Dialogue approach to social network meetings as a process whereby experiences can be spoken about for which previously there was no language (Seikkula, Alakare & Aaltonen 2001).

Several of the participants in this study commented on activities by members of the reception meeting team which they experienced as having expanded the conversation. As previously discussed, one of the ways that this was achieved by team members was through adopting a gentle or 'quiet', non-intrusive stance in the meetings. For some participants, the presence of the team members in itself appeared to have contributed significantly to the creation of a context which felt sufficiently safe for the previously unsaid to be openly expressed to others. Vicky commented:

Vicky: There was things that I wanted him (her husband) to know, but I could never tell him. But with someone else being there I've been able to do that.

Vicky also felt that the meeting provided her with the opportunities and the emotional strength to voice ideas and feelings to her father, ideas and feelings which had previously been 'untold stories' (Pearce & Pearce 1998):

Vicky: ...the strength came from the meeting, because I had a lot of things to say to my father that I couldn't say, and, I think the meeting was done in a way that it took away, eh, what can I say.... If I had of faced my father on my own, there would have been a full scale row. ...There would have been some nasty things said, there would have been a lot of nastiness. We probably would have fell out. But because it was done in the meeting, I was able to hear his point of view, and he was able to hear mine. Plus, there was other people at the meeting who didn't know my Dad, who were able to help- if need be change the subject, or talk about it, do you know what I mean? That was very, very helpful. There was no awkward silences with it being in the meeting, whereas there would have been if it had been just me and my Dad.

After initially speaking in more general terms about *"the meeting"* providing her with strength and support, Vicky went on to elaborate regarding particular qualities she associated with the staff's presence which created a context for a dialogical exchange to occur. A process of mutual talking and being heard occurred between daughter and father which was facilitated by the presence of people who she felt might intervene to prevent the conversation from breaking down if it became over-heated. Vicky also identified that the team's not having a prior relationship with her father was useful,

possibly because this allowed for a position of greater 'neutrality'[2] or even handedness. If the team members who were present had privileged the account of either Vicky or her father by communicating a willingness to listen more fully to one perspective than another, then opportunities for dialogue in which, as Vicky commented, she was *"able to hear his point of view, and he was able to hear mine"* may not have occurred.

Creating a safe context

The presence of the reception meeting team members appears to have represented for Vicky a kind of 'safety-net' for the conversation within the reception meeting. She suggested that the in the meeting the team members might potentially exert a subtle influence upon the conversation, steering it away from topics that felt unhelpful or over-heated, but also at times encouraging participants to continue talking about topics beyond a point where a particular issue or theme might previously have been avoided. The team members would, Vicky suggested," *if need be change the subject, or talk about it*". Systemic practitioners influenced by postmodern ideas have emphasized the importance of facilitating the conversational process, of 'keeping the conversation going', in order to promote dialogue and allow new meanings to emerge (Anderson 1993). Vicky's account of the reception meeting team's participation suggests that she viewed them as attentive to the process of conversation to prevent polarization from occurring or a re-emergence of the dominance of the 'unsaid', characterized by *"awkward silences"*.

The role that the team played in creating a context which felt sufficiently 'safe' for new, less heated conversations to occur between family members was also highlighted by Christine, a service-user who participated in the study. In the research interview, Christine spoke about the conflict that existed between herself and her family prior to the reception meeting. Christine identified the presence of the staff as being particularly significant in enabling a discussion to occur which was different and less fraught:

Christine: ...I had my dad there and my husband there, but then I'm glad that I had the right support from the nurses, the doctors, my CPN there to sort of smooth all the

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[2] The term 'neutrality' has become controversial within the systemic practice field. Originally introduced by Palazzoli et al (1980) to refer to an interviewing approach in which the therapist avoids 'taking sides' with any one person in the meeting, it became the focus of critique from some practitioners who felt that it implied emotional detachment or avoidance of an ethically and politically committed therapeutic stance. 'Neutrality' is used here to refer to a process of multiple-engagement by the practitioner with the different people and perspectives who are present.

problems out, because if there'd just been the three of us in the room together it would
have been sheer hell- it would have been World War Three, really, so I'm glad I had the
right people around to help.

Christine did not differentiate here between the members of the reception meeting team
who were specifically responsible for 'hosting' the discussion, and the contributions of
the other professional participants who were not members of the team. This may be
because all but one of the staff who were present on this occasion were involved in the
reception meeting team, and so the role of facilitator to the conversation may not have
been attached to one or two of the professionals who were present to the same extent as
might ordinarily have been the case. Like Vicky, Christine also experienced the presence
of those professionals who took part as supportive in a way that helped reduce anxiety as
well as decreasing conflict:

Christine: ...It was just sort of getting confirmation that everything's going to be OK.
Everything's going to be all right. Because I'm just a complete worrier, and I've just
been worrying myself sick recently about a lot of things. And being in that meeting and
having the right support and the right people around me just sort of confirmed that
everything's going to be alright.

The idea of the reception meeting itself, as well as the presence of the staff who were
involved appears to have evoked for several of the research participants feelings of
reassurance and safety. This is particularly striking as several of the participants,
including Christine, were detained in the Unit under Mental Health Act (1983)
legislation at the time that the meetings occurred. It might therefore be anticipated that
for those participants quite different, more authoritarian perceptions of the staff would
have been evoked. The reception meetings therefore appear to have been successful in
many instances in creating opportunities for more dialogical exchanges to occur even
though they occurred in a context which was extremely power-laden and frequently
characterized by asymmetrical relationship patterns.

Creating space for different perspectives

One of the factors identified as contributing to the development of a dialogical ethos in
the reception meeting for Christine by John, a consultant psychiatrist in the Unit and also
a member of the reception meeting team, was that the staff attended to Christine's point

of view in a respectful manner, rather than minimizing the significance of her account on the basis of her psychiatric diagnosis and her status as a detained patient:

John: I think she's (Christine) had an experience of being taken seriously by the professional team.... I think there are circumstances where somebody who seems a bit excitable and who is straying towards the boundaries of acceptable methods of argument, when they start talking about making important and significant life changes, you can see the staff, sort of trying to keep the situation on hold, rather than encouraging it too much, I suppose, working on the principle that when everything dies down then these plans will be dead in the water anyway, forgotten. And, I think perhaps it was the willingness of the professional staff in the meeting to accept her ideas about future plans as a valid point of view that was worthy of equal attention to anyone else's point of view, possibly, that could have been a thing that enabled her family to hear these plans as having important and reasonable backing somewhere.

Whereas practitioners who were strongly influenced by medical narratives might have attempted to ignore communications which were expressed in an unusual manner by Christine, regarding such talk as symptomatic of an underlying illness process (Birch 1991), a social constructionist perspectives invites curiosity not only about multiple narratives but also different approaches to the activity of telling one's story (Pearce & Pearce 1998). Respectful listening to the service-user's account by the professionals in the presence of the family may have the effect of 'legitimizing' the story told; in other words, since mental health practitioners are 'Experts' in what areas of talk should be categorized as 'sane' or otherwise (Andrews et al. 2000), their respectful engagement with the service-users story conveyed to family members that what was being said had important meaning, equal in validity to the ideas expressed by others taking part in the reception meeting.

Christine herself described the processes that occurred in the reception meeting in similar terms. Prior to attending and in the early phase of the meeting, she felt trapped in a problematic cycle of interaction in which her views were negated by her family:

Christine: It was moving quickly, yes. I was trying to get a message across, and my Dad was talking about something completely different, you know, he was sort of swaying it in a completely different direction, and it was getting a bit frustrating- kind of, "Listen to me! You know! I'm here, listen to me!"

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During this early phase the ethos of the meeting appears to have been extremely fraught, unreflective and monological, with people talking over, rather than with one another. Christine describes how Colin, a member of the reception meeting team, intervened in what was potentially an escalating pattern of conflict between father and daughter:

Christine: Then somebody noticed, I don't know if it was you, or somebody else noticed- the guy sitting on my right, Colin- he noticed that I was getting a bit frustrated that my Dad wasn't listening to me, and then he butted in and said, "Hang on a minute, get back to the point", you know?

Although Christine describes Colin's intervention in terms which imply that he adopted a rather impositional style of intervention by 'butting into' the discussion to interrupt a repetitive and unhelpful pattern of family interaction, the effect appears to have been to create increased space in the meeting for her voice to be heard by the family, rather than her words being ignored or talked over.

The importance of the team members attending to the multiple perspectives and needs of the participants in the reception meeting was also highlighted from a family member's perspective by Brenda, who attended a reception meeting after her son Nick was admitted to the Unit under the Mental Health Act (1983). Brenda, commented upon this when discussing the contribution of Laura, a member of the reception meeting team:

Brenda: I like Laura's point of view, because she can come out with something that's totally different. Because... I don't know why, I feel safe with her, because she doesn't just listen to the patient, who's the most important person, she's also listening to you and thinking, "you've got a problem as well, do you want to talk about them?".

For Brenda, feeling "safe" equated with feeling listened to. Laura's attention to the differing, and occasionally conflicting, perspectives and needs of family members as well as of the service-user created a context in which Brenda appeared to feel that her position had been acknowledged, and therefore allowed for conversations in which the "circle of the expressed' was widened, and which were different in kind from those that the family usually engaged in with one another, and also possibly with other professionals. Tom Andersen, a family therapist influenced by postmodern ideas comments:

Conversations have to be different from what clients are used to bring about change, but not too different or unusual. ...For therapeutic benefit it is important that the therapist be sensitive to the flow of conversation, introducing change at a pace appropriate for the individual client. (Andersen 1993a, pp. 306-307).

The experience of reception meeting team members influencing or gently 'nudging' the conversation towards areas which have not previously been discussed openly is again highlighted by Brenda when discussing an episode of interaction that occurred between Okeke, a team member, and her son Nick:

Brenda: I found it very helpful when... I found it very interesting Okeke asking Nick, "How would you feel if things didn't go to plan?". You've got to get on with life and accept things, and that was very good. I found him very interesting, coming out with things that haven't been... (pauses).

Participants in the research identified a number of episodes within the reception meetings when the team members who were hosting the discussion made contributions of the sort described by Brenda, which had the effect of opening up space for new areas of conversation. The contributions by team members which research participants described as helpful tended to be facilitative in nature; that is, rather than providing 'psychoeducational' information to families regarding the diagnosis of the service-user or discussing technical aspects of psychiatric treatments, the interventions made by team members tended to be focused upon opening up conversation between participants. This appears to have occurred in a number of ways: through participating in the meetings in a relaxed and 'quiet' or unobtrusive manner, rather than dominating the conversation or 'bombarding' participants with questions; through relating to the others present in an 'even-handed' manner, respectfully listening to the different accounts of the people present; and through occasionally 'butting in' or 'nudging' the conversation towards areas which might previously have been avoided by family members. This interactional style appears to have contributed to the development of an ethos of 'safe uncertainty' which is, according to Mason (1993), a necessary condition for dialogue. When relating from positions of safe uncertainty, participants could therefore risk expressing to others concerns that had previously remained unspoken.

Stories about the reflective processes

Members of the reception meeting team also drew upon the idea of 'reflective processes', as developed by Andersen (1990) in a further attempt to generate dialogue within the meetings, (see chapter 3 for a discussion regarding the theoretical and practice principles associated with this reflective approach). Because the reception meetings occurred at what was often a particularly fraught time for families the ability to speak confidently and to listen attentively to others might often have been impaired for the individuals concerned. When emotions are running high, it is often particularly difficult to attend carefully to the words of others, or to entertain different perspectives. Maria, who attended a reception meeting after her mother Caroline entered the Unit, described feeling this way:

Maria: It was like that many things was going on in my head anyway, and with the last two months or something of being there with my Mam, it was like, I had loads and loads of things still going on in my head, so it was like... to sit and listen all the time, I was like looking out of the window at some points, because I was like totally full of everything really.

Feeling overloaded in this way potentially mitigates against engagement in a dialogical conversation, which entails interacting both with one's own 'inner' voices as well as with the 'outer' voices of the others who are present (Seikkula 1993). Maria suggested that in the reception meeting she attended the reflective discussions that occurred between staff were particularly helpful in allowing her to listen and participate in the conversation differently. In particular, these reflective discussions provided Maria with an opportunity to listen to the conversation of others without feeling pressurised to participate directly:

Maria: But then when- was it Jack (reception meeting team member) that was sitting there- and the other woman, when those two started speaking it was a lot easier. When those two were- like you were able to pick up on things- because there's questions that you want to ask, but then you're forgetting all the time. I had loads of things that I wanted to ask but at the same time when it came to it I was, they were gone, you know? But as soon as those two started talking about what they felt about what was happening, it was easier to pick up on that.

Andersen (1995) suggests that reflective processes allow participants in a meeting to engage in this process of moving between 'talking positions', where they are engaged in outer dialogue with others, to 'listening positions' when they are engaged in dialogue with themselves, with their own inner voices. The style of the reflective conversation, in which team members speak in tentative, speculative terms, and avoid making direct statements or addressing questions directly to those who are listening allows for a less pressurized form of listening; a form of listening which doesn't require an immediate reply from the listener. For Maria, the reflective conversation of the staff seemed to provide a sense of relief. This may be in part because she felt that the staff demonstrated through their comments that they, in turn, had listened to what Caroline and the family had said:

Maria: Yeah, and they picked, I think, up on what was happening and that, and how my Mam felt, I think. Yes.

Later in the interview, Maria reiterates that she found the reflective process a particularly helpful aspect of the reception meeting. When asked if she had any suggestions about how the reception meetings might be improved, she recommended, *"more of the sitting back and listening"*.

Members of the reception meeting team engaged in these reflective conversations from time to time in the meetings, rather than as a matter of routine. A number of factors seemed to influence the decision about whether to use this approach in specific meetings. Because reflecting team conversations involve a departure from ordinary social forms of interaction in that the people who are reflecting in this way avoid making eye contact with those who are listening, the members of the reception meeting team would attempt to exercise judgment about whether this process might be over unusual for those present at a particular time. Holly, a staff nurse in the research site, discussed her experiences of having attended several reception meetings, some of which included reflective discussions between members of the reception meeting team, and some which didn't. Like Maria, Holly identified the reflective conversations that team members engaged in as providing an opportunity for the others involved in the reception meeting to listen in a reflective and non-pressurized manner:

Holly: I quite liked it, because I thought that it gave..., you were sort of giving each other eye-contact, therefore everybody else was... (pauses) the pressure was off them for a little bit. And it sort of gave them time to reflect, while you were, well that's what you

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were doing, I suppose, but it gave them time to reflect and collect their thoughts, and then perhaps you were sort of summarizing things for them, which I think sometimes when you're in that sort of meeting is quite useful. So I think I liked that better, when that was going on. I think that was probably more useful.

While Maria and Holly both spoke about the team's reflective discussions within reception meetings in positive terms, some research participants expressed ambivalence about this aspect of the meetings. Dan, a nurse on the Unit, discussed his experiences of attending two reception meetings, one of which he felt was successful and the other unsuccessful. In both instances the reflecting team conversations seem to have been significant in shaping these responses:

Dan: I think they're a good idea. I've seen it (the reflecting conversations) work and I've seen it not work, I've seen both.

Alex: And the one that wasn't such a success, what was it that made it unsuccessful?

Dan: The client felt it was very, eh, it was distant. At the point where the two people talk by themselves, he couldn't really see the significance of that. He felt a bit awkward about it. He said he didn't know why they did that, he didn't see the relevance of it. And I could understand why that would seem a bit strange.

The team's attempts to engage in reflective discussions seem to have evoked a feeling of embarrassment for the service-user in this reception meeting, and to have created a distancing effect. This may have occurred as a result of the rationale for the team's unorthodox conversational approach not being sufficiently well explained to the others in the meeting, or because this style of discussion was simply experienced as too unusual and therefore viewed as unhelpful. In the other reception meeting that Dan attended, however, the teams reflections appear to have been a positive experience for the service-user:

Alex: Did that happen in the other meeting, the one that was successful?

Dan: No, they said to me that that was a good part of it.

Staff engaging in reflective conversations can therefore have a powerful influence on the ethos of a meeting. Some participants in this study identified reflective conversations as particularly beneficial in providing opportunities for participants to listen and think more reflectively; opportunities to stand outside of the stressful feelings which are generated by the crisis of hospital admission and the events leading up to it for a moment, and to attend to what is being said by others more clearly. At other times, however, staff attempts to talk reflectively in the meetings had an opposite effect, leaving the others who were present feeling puzzled and excluded.

Potential indications for the use of reflective processes in network meetings

The importance of avoiding the use of reflective processes in a routine or ritualised manner was highlighted by John, a member of the reception meeting team, who suggested that when conversations are flowing quite freely the use of this method is unnecessary. John felt that reflective discussions between staff can be particularly useful in creating increased conversational fluidity in those situations where there is a rigid or taut quality to the interactions that are occurring:

John: Yeah, I eh... I find myself drifting in and out of reflection being an important part of the meeting or not. I suppose, my sense of that meeting was that it turned out to be a kind of open meeting where things were getting discussed, where there was useful or important movement of some sort, and, eh, I didn't find myself thinking, "this is a time when there should be some reflection, because things are too stuck, or whatever, or because people need to hear a different story". I can think of other reception meetings where there's this very tightly scripted story that's.... it's like, eh, do you know that children's toy that comes from South America, it's kind of a woven basket-work tube, and you stick your finger in it, and no matter how hard you pull- the harder you pull, the harder it is to get your finger out, so you.... and it's those sort of conversations- the equivalent conversations, where I think directly using the reflective process helps to take the unhelpful or anchoring pressures out of the situation, and allows people to come back into the situation kind of sideways, or from a different angle.

The metaphor of the South American children's toy vividly evokes monological interaction in which participants rigidly adhere to fixed positions in the discussion and in which the ability to entertain alternative perspectives is absent. When participants find themselves 'stuck' in this form of interaction, John proposes that reflecting processes

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can be a helpful means of generating difference. This is a view which has also been expressed by Pearce and Littlejohn in relation to the field of conflict resolution:

"The purpose of reflecting is to give the participants pause, to stimulate their own reflecting, and to open space for new action and forward movement" (1997, page 203).

When the conversation that occurs in reception meeting is less rigid and more open, however, John suggested that it would be unnecessary for staff to structure their conversations in this way, since movement and change is likely to occur anyway, without requiring this. Similarly, Andersen (1993a), the originator of this style of reflective process suggests that reflection is intrinsic to 'ordinary' conversation in which participants engage with one another respectfully and attentively:

"I have come to believe that a normal conversation gives each person who takes part the possibility of being in a personal reflecting process, that is, of shifting between inner and outer dialogues with an interested Other present..." (page 311).

The idea of reflecting conversations by staff as a kind of 'lubricant' for stuck conversations may be useful, but also requires sensitivity to the expectations and the levels of anxiety that the people participating in the meeting might bring. Brenda, a family member who had previous experience of a reflective process approach in family therapy sessions prior to attending a reception meeting warned that although these reflective conversations can be helpful, they might also be experienced as overwhelming for families with a relative who has recently entered hospital for the first time:

Brenda: I don't think they (the reflecting conversations) should occur straight away on an introductory meeting. Maybe at a later stage, but not at first, because I think it would be too much on other people. I mean, I'm okay with that, but somehow when I picture other people, it's a bit horrendous. Especially the first time.

At times of great stress or anxiety, receptiveness to unusual occurrences may be reduced, and families are already faced with a situation which is unfamiliar when a relative is admitted to a psychiatric in-patient unit for the first time. Brenda warns that under such circumstances, staff engaging in reflective conversations may be, in Brenda's words, *"too heavy"* for families. On the other hand, the account provided by Maria which was discussed earlier suggests that reflective conversations by staff can in some instances help to alleviate feelings of stress for family members.

Careful 'reading' of the emotional climate of individual meetings and attention to whether the conversation is monological or dialogical in nature is therefore required by staff who are facilitating network meetings in this type of organizational context if reflective formats are to be introduced successfully. Again, sensitivity to the nuances and 'moods' of the meeting requires from staff a 'knowledge of the third kind' (Shotter 1993); that is, knowledge regarding how to position oneself within relationships to open up opportunities for movement and accessing new perspectives by others. This type of knowledge is described by Shotter in the following way:

*"Such a form of knowledge cannot be formulated in terms of facts or theoretical principles ("knowing that"), for it is a form of practical knowledge, relevant only to particular concrete situations. But it is not practical knowledge in the technical sense of a craft or skill ("knowing how"), for it is knowledge which only has its being in relation to others. ...Indeed, unlike the other two kinds of knowledge, it is knowledge of a **moral kind**, for it depends upon the judgment of **others** as to whether its expression or its use is ethically proper or not.... It is the kind of knowledge one has **only from within a social situation**, a group, or an institution, and which thus takes into account (and is accountable to) the **others** in the situation from within which it is known".* (Shotter 1993, p.7).

Practitioners employing this form of knowledge are guided in their actions by the specifics of the local, relational context they are acting into, rather than relying upon generalized criteria or templates for good practice. This is not to say that such criteria and guidelines have no value, but rather that they are regarded as provisional and adapted the requirements of the situation at hand, rather than being applied routinely across contexts.

Summary and discussion

In the process of undertaking multiple readings of the data generated for this study, as recommended by Brown and Gilligan (1992) in their 'listener's guide' for a relational research approach, I was struck by the quiet presence of the reception meeting team. While the team were frequently mentioned in the stories told by research participants, they rarely seemed to occupy centre stage. This 'background' position didn't, however, mean that the team's participation in the meetings was viewed by other participants as

unimportant. Many of the research participants spoke appreciatively about the presence and contribution of team members, using terms such as *"informal"* and *"relaxed"* to describe their approach. This rather quiet, unobtrusive practitioner style echoes several accounts of the role of the therapist from within the postmodern family therapy literature. White (1995), for instance, speaks of the "decentred" therapist who draws upon the knowledge and abilities of the social network or community which surrounds a person. The hierarchal relationship between professional and service-user that characterized more traditional therapy approaches is deconstructed, with the resources for change instead being regarded as located within the network. Similarly, in discussing participation in dialogical patterns of human communication, Pearce & Littlejohn (1997, p.214) suggest that, *"To have a dialogical conversation is to value listening more than speaking, to value understanding more than explaining, and to value respect more than persuasion"*. Data presented in this chapter suggests that there was parallels between these descriptions of a postmodern, dialogical therapy style and the manner of participation in reception meetings that team members engaged in.

Although team members avoided participating in the reception meetings as 'knowing Experts' who could 'instruct', 'educate' or 'treat' the service-user and family, this is not to say that their presence and contributions was described by other participants as lacking in authority or expertise. The presence and manner of team members frequently appeared to contribute to an ethos of 'safe uncertainty' (Mason 1993) in which participants could begin to voice stories that were previously untold or unheard, and in which family members could talk about potentially contentious issues without the discussion becoming overheated or polarized. To return to a point raised at the beginning of this chapter, to adopt a 'not-knowing position' does not mean that the practitioner does not have knowledge, abilities and experience that they bring to the situation. Instead, it entails the sort of 'knowledge of the third kind' described by Shotter (1993), an ability to position oneself sensitively in relationship to others within particular contexts in order to open out conversational opportunities.

In addition, some degree of authority is inevitably invested in the team members as a consequence of their professional position. This authority and expertise that is invested in psychiatric professionals might often be experienced by service-users or family members as distancing, inhibiting or oppressive, as when Maria spoke about feeling that team members were quietly analyzing her in a reception meeting. Data presented in this chapter also suggests, however, that there was several occasions when this professional authority was employed in a manner which was experienced by participants as useful.

Respectful listening by members of the reception meeting team to the account of a service-user which had previously been dismissed by family members as 'crazy talk' might allow the story to be heard more positively within the family, for instance. As well as creating an obstacle to dialogue under many circumstances, the authority associated with the position of psychiatric professional may therefore also be employed in a manner which is potentially empowering or liberating to others. Since this professional authority can never be entirely 'shaken off' (Andrews et al. 2000), an awareness of the power that is invested in us as psychiatric staff is crucial if we are to position ourselves sensitively, reflexively- 'knowingly'- in our relationships with others who occupy less powerful positions.

Part four:

Discussion

Chapter 11. Towards dialogical practice with families in psychiatric settings

Postmodernism, for some, represents an 'end to Theory'. Newman (2002), for instance, has argued that the last thing that a postmodern, narrative approach to human relationships needs is a generalized theory of narrative. Story, according to Newman, is a non-explanatory way of attributing meaning to human life, to the domain of things which is, at the end of the day, unknowable. Other postmodern and social constructionist writers have called not so much for an end to theory as a bridging of the traditional theory / practice divide. A key aim of studies undertaken by many researchers who adopt a social constructionist framework, as well as of action research and practitioner research, is therefore to generate 'practical theory'; that is, theory which engages with the dilemmas and tensions facing practitioners and which aspires to contribute to the betterment of our social worlds (Shotter 1993). In 'theorizing' about the data presented in previous chapters (chapters 7, 8, 9, and 10), the discussion that follows will be grounded in, and attempt to maintain relevance to practice-based concerns.

Generalizability, validity and postmodern research

Since a postmodern orientation to research is primarily concerned with the specificities of particular situations, it is important to preface the discussion that follows with a consideration of the type of knowledge claims I am making for the research. Postmodernism emphasizes the situated nature of knowledge and as such, is committed to and constitutive of difference rather than generalities. Fox (1999, p. 177) writes:

"All knowledge must depend not only upon the setting, but also upon who is doing the observation, and under what circumstances. ...there is little possibility of becoming context-independent. Consequently, it is unlikely that research findings can be generalized beyond the setting in which they were gathered".

While this position is valuable in challenging the idea of research 'findings' as oppressive grand narratives that practitioners should unquestioningly incorporate into their practice, it also poses enormous dilemmas for practitioners, managers, planners and educators as well as for the research community. Practice that is informed by a social constructionist understanding is 'essentially' improvisatory, in the sense that it entails

responsive engagement with the specificities of a particular situation rather than adherence to a template for action (McNamee 2003). At the same time, however, the social world is relatively patterned; life is not so full of surprises that it we can make no comparisons between situations and events. A postmodernism emphasis on fragmentariness invites scepticism regarding the predictive value of theory derived from previous research, but these theoretical accounts help us to remain alert to possible patterns and act as indicators regarding what might be tried in similar circumstances (Polkinghorne 1992). In considering the generalizability of narrative accounts developed through qualitative research, Kennedy (discussed in Kvale 1996) develops an analogy with case law. In case law a new principle is derived from a particular case. The applicability of this principle to future cases is made through comparison and the development of arguments for its application, based upon rich and detailed descriptions of the specifics of each new situation. It is not generally expected that the principle will be wholly accepted or refuted in future cases, but rather that it will develop through use.

This case law analogy is helpful in considering the applicability to other practice settings of 'principles' or 'themes' extrapolated from stories generated through this research. If utilised in some form, ideas developed in this study will inevitably be modified and so transformed. Implications that are drawn are therefore presented tentatively as possibilities that might have value in other organizational settings where broadly similar circumstances are in place, nothing more. This position is congruent with Polkinghorne's (1992, p. 152) account of a 'postmodern epistemology of practice'; that is, knowledge which comprises a body of metaphors or tentatively held theoretical principles which are derived from previous practice experiences, and which serve as heuristic devices that can guide action in new situations. These metaphors and principles are always unfinished and in need of revision as new ways of 'going on' in practice situations are discovered.

Validity

Reed and Biott (1995) argue that different criteria need to be applied when evaluating practitioner research from those which are commonly applied in relation to more traditional research approaches. Because of the 'insider' perspective of the practitioner researcher and the explicit commitment to practice development, for instance, criteria regarding 'objectivity' or 'neutrality' are not relevant. In addition, if the term 'validity' is taken to refer to the extent to which the study has used correct methods and procedures which allow for an accurate 'representation of reality' then this term is

clearly problematic when applied to research which adheres to a constructionist methodology. These authors propose that one of the most important criteria against which the validity of practitioner research should be considered is its potential to catalyse new practice developments. Similarly, Annells (1999, p.11) argues that the when considering the validity of a particular study, practitioners should consider the extent to which the product is understandable and useful. It is my contention that the validity of this research should therefore be considered in relation to the extent to which the themes or 'findings' presented in the chapters that follow are useful to practitioners in guiding, illuminating or stimulating their work with families in similar organizational settings.

A further criteria suggested by Annells relates 'congruence'; that is, the extent to which that the approach used in the research was congruent with the aims, purpose or desired function of the study. Kerr and Fitzpatrick state that each research strategy, *"stems from a differing philosophical base which affects the aim and object of inquiry. The researcher choosing one of these strategies is advised that the question asked must be congruent with the underlying philosophy and research strategy chosen to answer the question"* (cited in Annells 1999, p. 12). In the present study, for instance, I was careful to select and adapt interpretive procedure for analyzing the data which was congruent with the postmodern methodological position I have adopted, and with the research aims which were primarily concerned with enquiring about the participants experiences of power and voice in the reception meetings.

One of my aspirations as a researcher has been to produce a text which is 'multi-voiced' in which the different voices of the research participants are included. Thorny questions are raised, however, regarding the extent to which it is possible for a research text to 'represent' the voices of others, without the researcher imposing his or her own perspective (Wilkinson & Kitzinger 1996). This question is particularly resonant within the power saturated social field of psychiatry, because of the potential for members of a dominant 'professional' group to appropriate or distort the voices of the marginalized 'Others' (the service-users) in the interests of maintaining the status quo. bell hooks writes:

"Often this speech about the 'Other' annihilates, erases: 'no need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Re-writing you, I write myself anew. I am still the author, authority. I am still the colonizer,

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the speaking subject, and you are now the centre of my talk". (cited in Wilkinson & Kitzinger 1996, p. 11).

For hooks, the 'solution' to this process of colonization is for those occupying positions of dominance to cease from attempting to represent the voices of the marginalized 'Others', and allow those who are powerless to speak for themselves.

Alternative understandings of the problem of 're-presentation' are offered within postmodern writings. Postmodern research, with its focus on language is concerned with the textual nature of life and with the interpretation of texts (Fox 1997, p.42). Texts may be spoken, written or bodily practices. They are products of human activity, created within the flow of time, and open to endless re-interpretation and with no single, fixed meaning. As such, there is no original meaning that was intended and voiced by the speaker that can be recaptured through processes of analysis. From this perspective, we are engaged an endless interplay of texts with one another. It s impossible for any reading to capture an essential meaning and there can always be other points of reference for a text. Fox (1997, p.42-43) offers the following propositions which assert the relevance of this idea of textuality for research into the social world: Firstly, he argues that in the study of the social, the primary unit of analysis is the text. Secondly, Fox contends that texts engage with each other productively. It is through this interplay of texts that meaning is created, sustained, obscured or re-introduced. The capacity to engage with the social world meaningfully, to understand and contribute to that world, is necessarily inter-textual. Finally, Fox argues that since the 'meaning' of a text is never intrinsic, meaning is constructed at the point where "where text's collide", at the meeting, for instance, of the participants words and the act of interpretation by the researcher. Since interpretation of a text is always an act of power, such interpretations should also be necessarily be regarded as provisional and subject to challenge.

In creating this research text, I have drawn upon the principle of 'juxtaposition' (Chenail 1995)[1] to generate a 'multi-voiced account, since, as Fox (1997) has argued, marginalization occurs through the denial of inter-textuality which might enable alternative discourses to express their own positions. The dominance of particular texts is maintained by divesting others of the capacity to speak 'authoritatively'. Juxtaposition of the voices of research participants who occupied different social positions within the research site (service-users, family

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[1] As discussed in the 'Summary' section of Chapter 6.

members and professionals) has therefore been used as a strategy in this text for resisting the dominance of any one position or perspective within the research narrative.

The research aims revisited

With aspirations towards the development of this practical theory in mind, in this chapter I am principally returning to the practice issue which initially provoked my curiosity and led me to embark on this research journey in the first place. That is, as a systemically trained practitioner, I was interested in exploring the contribution that systemic ideas might make in the development of services for people who enter psychiatric hospital and their families. In attending to the multiple and diverse voices of service-users, significant others and staff, a systemic perspective potentially offers opportunities for less impositional forms of practice than does a more traditional, individually-focused psychiatric approach which elevates a biological conception of distress at the expense of contextually-sensitive understandings. In view of the theoretical and ideological differences between systems thinking and the medico-psychiatric framework which tends to inform professional practice in in-patient units, it is unsurprising that there are relatively few examples from within the previous literature regarding systemic family or network-based approaches in these settings.

In seeking examples within the literature of innovative family and network-based practice in hospital settings, the writings of the Finnish psychologist and family therapist Jaakko Seikkula and his colleagues served as an important source of inspiration to myself and my systemically-orientated colleagues within the research site (Seikkula et al 1996). As previously discussed, this Finnish social network approach provided something of a blueprint for the reception meetings that were developed in the research site.

Inspirational as they were, I felt that the articles produced by Seikkula and his co-workers left some important questions unanswered, and it was these questions that I have attempted to explore in this study. One of the areas that had not previously been explored in the literature was the question of what the service-users and family members themselves felt about participating in the network meetings. Since the aim of the meetings was to generate dialogue between families and staff and enhance collaboration, this was a crucial omission. For this reason, the data generated in this research reflects

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the multiple perspectives of the service-users, family members and staff who participated in the reception meetings. It has been my aspiration to (co)create a polyphonic text in which multiple voices are 'present'.

A second, and equally crucial, dimension of practice which was not addressed in the Finnish literature concerns the tensions between a postmodern dialogical form of practice and a modernist treatment context in which 'correct' understanding of the nature of 'mental illness' is considered to be the specialist province of professional experts (Andrews et al. 2000). Drawing upon Bakhtinian ideas about how realities are linguistically constructed through dialogical encounters, Seikkula and his colleagues conceive of the biological account of psychiatric disorder as another story, one amongst many. There is relatively little discussion of the different status accorded to particular narrative accounts within any cultural context, and how the medical / biological narratives are deeply embedded within the social order of Western societies. Medical psychiatry is an important instrument of social control, and so the biological narratives that justify its methods comprise a powerful hegemony of knowledge (Geist and Dreyer 1993). Discussing the tensions associated with attempting to practice therapeutically in a psychiatric secure unit, Vivian-Byrne (2001, p. 107) identifies similar tensions:

"Does this situation, by definition, make it impossible for the system, which detains patients against their will, also to engage therapeutically with them? Is this a 'both / and' too far? To what extent can a professional in this context carry out a useful and ethical job both for the patient and the societal system they serve?".

Although this author is discussing experiences of working in a forensic context where there is necessarily a strong emphasis on custody, these questions are also pertinent for less specialized in-patient units such as the research site, since coercion and custody are 'realities' which need to be grappled with in all psychiatric institutions.

Perhaps one of the reasons why these questions have not been examined in depth in the Finnish literature is that there is a stronger tradition of psychological approaches running alongside medical treatments within their public sector psychiatric services than is the case in the UK (Reed 1998). Psychoanalytic and systems-based approaches to the treatment of severe 'psychotic' disorders are represented in standard clinical practice in many areas of Finland (Alanen 1997), whereas 'talking treatments' of these sorts are something of a rarity within mainstream services in the UK. Questions about the 'transportability' of dialogically-based approaches from Scandinavian culture into

mainstream UK psychiatry were therefore important to consider in this study. Anderson (2002, p. 281) also raises this question of how the Finnish approach can successfully be transferred to different settings, asking, *"How can therapists translate the approach, which evolved in such a unique cultural context near the icy tip of the world to other cultural, organizational and political contexts?"*.

Discussing the tensions between postmodern systemic therapies and medical psychiatry, Vivian-Byrne, (2001, p. 108), paraphrasing Flaskas, suggests that the culture of UK psychiatry is typified by the modernist equation which can be outlined as, *"external reality-objective knowledge-certainty about that knowledge-claim to truth-expert status given to the holder of the truth/knowledge"*. Similarly, Good (2001) has also discussed the challenges to the 'objective', 'scientific' language of traditional psychiatry presented by a polyphonic practice which aspires to engage with the previously marginalized, 'personal' narratives of service-users. Geist and Dreyer (1993) have also emphasized the contrast between a participatory, dialogical model of the 'health care provider / service user' encounter and the more traditional relationship which centres around the 'Expert' professional and the passive recipient of treatment.

The issue of how power and authority might be addressed in the network meetings occurring in hospital settings is therefore both complex but also of central importance. Entering psychiatric hospital can result in a profound sense of disempowerment and loss of voice, and it is therefore important that a context is created in which these subjugated voices can find expression, where 'stories lived' can become 'stories told' and 'stories heard' (Pearce & Pearce 1998). For many of the service-users who participated in this research, the reception meetings they attended appear to have been an empowering experience, in which they (re)gained, and found opportunities to use, their own voices.

In the discussion that follows I will explore in greater detail some practice issues associated with these tensions that have been highlighted between a systemic and dialogically orientated approach to practice and a psychiatric hospital setting which carries both therapeutic and social control functions. A range of issues will therefore be examined which are associated with this central dilemma regarding the feasibility of generating genuine dialogue in a context where asymmetrical power relationships

potentially pervade every interaction, and in which these power relationships remain largely unacknowledged[2]. These themes and issues will include:

- Considerations regarding the composition of network meetings and the complex implications arising from the process whereby this is negotiated and what is agreed.

- The notion of different socially constructed 'conversational domains', each with their own particular sets of expectations and criteria for action, as well as specific opportunities and constraints (Lang, Little & Cronen 1990). I will propose that this concept of 'domains' offers a useful framework around which practitioners can negotiate relationships with participants in network meetings to reduce the likelihood of expectations becoming confused and to establish clarity regarding the 'givens' which are operational in this kind of agency setting.

- The issue of the degree of initial uncertainty experienced by participants in the reception meetings will be revisited. I will suggest that Mason's (1993) concept of 'safe uncertainty' provides a useful framework for practitioners aspiring to engage in dialogical conversations within the potentially fraught environment of a psychiatric admissions Unit. I will go on to argue that staff facilitating network meetings will need to consider the extent to which all who are present (staff, as well as service-users their and 'significant others') experience a sufficient sense of safe uncertainty so that they do not retreat into the more predictable and monological patterns of communication associated with interpersonal 'closure'.

Group composition, hierarchy and experiences of voice

Data generated for this study suggested that the participants were often extremely sensitive to the group composition of the reception meetings. This was an important factor influencing the opportunities for open talking; that is, which stories the participants felt could and could not be discussed. Some degree of discomfort with the experience of talking in a group setting is perhaps inevitable in view of the twin contextual factors of a psychiatric culture which is strongly orientated towards the individual as well as the individualistic value base of western liberal-humanist society (Sampson 1989). The important principles of respect for privacy and confidentiality

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[2] According to Foucault, the workings of power are largely 'invisible' in ordinary social exchanges; these workings only become 'visible' at moments when there is some challenge or struggle in relation to the maintenance of the usual distribution of power (Parker 1989).

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associated with these cultural influences may at times, inadvertently, mitigate against more inclusive, family orientated psychiatric practice (Carpenter 2002).

For some participants the absence of a doctor in the reception meetings was particularly significant in allowing them to feel sufficiently safe to speak more openly, since medical staff are often invested with considerable authority in Western culture, (see chapter 8). Vicky, for instance, described the meeting she attended in particularly positive terms as providing an opportunity for the previously unsaid to be spoken about with her family. The presence of a doctor would have stifled her voice, she felt, because of the authoritative status of medicine, and what she perceived as the 'formal' nature of the discussions that typify 'doctor / patient' relationships. If a doctor had been present, she suggested, medical narratives regarding her difficulties would have prevailed, erasing the more everyday, lifeworld concerns about relationships that were a source of tension within the family; in other words, she commented, *"there would be nothing said"*. Interestingly, this perception of doctors as authority figures who were exclusively interested in a limited range of medical concerns such as diagnosis and drug treatment was also shared by some of the professionals who participated in the study. It was therefore suggested by these participants that it was preferable if the medical staff did not attend the meetings, to avoid this stifling process occurring.

Bakhtin discusses the difficulties in allowing private, 'inner' speech to become 'outer' speech in social contexts where there is a wide distance between the 'official' and 'unofficial' languages, perspectives or ideologies: *"whose words we can use in expressing ourselves is not entirely up to us, for even as we speak, we must anticipate the responses of our listeners to what we are saying"* (cited in Shotter & Billig 1998, p. 19). If the voices of participants in social network meetings are stifled because they feel that their comments will not be heard or taken seriously if they contrast with the orthodox psychiatric perspective, then these voices are likely to remain incoherent or undeveloped, as it is in the process of shifting between inner and outer conversations that speech and particular ideas become formulated and develop clarity and rigour.

One way that practitioners might facilitate an experience of increased voice for service-users is therefore to offer choices regarding who should be invited to attend a reception meeting. Andersen (1990, p. 51) has argued that careful negotiation regarding who should be asked to participate in a conversation at a particular time is crucial to the process of dialogue:

"...many therapists want to make a conversation with a group of people who are not able to exchange ideas at that certain point in time. So one of the questions we find very important to deal with is, "Who can talk to whom about this issue in which way at this point in time".

Attempts by staff who are convening network meetings to 'force' the issue by insisting that all of those people who are participating in the 'problem-determined system' should attend are therefore likely to be counter-productive in their effects if those concerned do not yet feel ready to do so.

On the other hand, in attempting to create a context in which participants feel sufficiently comfortable and safe to speak freely, there is a danger of simply sweeping the issue of power under the carpet. While the non-inclusion of medical staff or others who are perceived to occupy positions of greater power might in some instances allow those participants who occupy less powerful positions within the system to speak more openly, this process might also unintentionally serve to maintain the dominance of the medical narrative along with stereotyped perceptions of the medical team. Admission to psychiatric hospital is likely to result, in most instances, in the attribution of a diagnostic category and the prescription of psychotropic drugs to 'treat' the 'illness' that has been identified. These 'realities' must therefore be engaged with if the voices of the service-users, family members and professionals who participate in the reception meetings are to be heard in a way that matters, in the sense of having a voice in decisions about their own future treatment.

The absence of medical staff in many of the reception meetings also potentially served to maintain unhelpful cultural stereotypes of them as aloof 'deity like' figures who had no interest in the everyday world of human problems and relationships. These rather one-dimensional stereotypes were not only constraining for others, but were also potentially stifling for the doctors themselves. One of the senior medical staff who participated in this study spoke, for instance, about the frustrations associated with his professional role and how this at times impeded his ability to practice reflectively with families, (see chapter 7). Participating in a dialogical process in the reception meetings might provide opportunities for all participants to enrich their understanding of the situation and create new opportunities for relating differently with one another.

This tension between creating choice for service-users regarding who should attend a reception meeting and ensuring that the meeting isn't perceived as irrelevant to the

overall treatment process because 'key' individuals are absent might have been avoided if there had been greater capacity within the research site for subsequent meetings to occur where this seemed appropriate. The rationale for the reception meetings being 'one off' events was largely resource driven: it was often difficult enough in this setting to gather people together for a single meeting, and so arranging subsequent meetings would have provided a major organizational headache in most instances. However, in the Finnish model that was an initial source of inspiration for the reception meetings, network meetings were the primary form of treatment and so the meetings occurred as frequently as was considered to be necessary (Seikkula et al. 1995). If this flexibility had been available within the research site, it would have been possible for staff and service-users to negotiate who should attend the meetings across time, with the potential for a gradual widening of participation. Seikkula (2002, p.284) has argued differently, that it is a *"prerequisite ...in every case to include those nearest the patient ("social network", e.g. family, friends, others who know and care about the patient) in the first meeting to guarantee the beginning of a construction of joint language"*. This inclusive position enables the process of dialogue and shared understanding, but must be balanced against the danger of negating the service-users wishes by imposing a professionally-determined notion regarding the correct way to proceed.

Returning to the fundamental question regarding whether it is possible to create a forum in which genuinely dialogical encounters can occur in an organizational context which is strongly orientated towards custody and control, many of the participants spoke about the reception meetings as providing opportunities for different voices to be heard and for new, more connected relationship patterns to evolve. At the same time, there are limitations on the degree of collaboration that can occur, and the 'realities' of power and control inherent within this social field require acknowledgement. Failure to address these aspects of the psychiatric system might result in the meaning or significance of the conversations that occur in a reception meeting being diminished by subsequent experiences within the service. Peter, a service-user who was detained in the Unit under Mental Health Act (1983) legislation, highlighted this issue when interviewed for the study. Peter spoke about the reception meeting in extremely positive terms, describing the discussions that occurred there as *"productive"* and having *"set some wheels in motion"*. Subsequently, however, this sense of progress was not maintained for him:

Peter: I don't know, it seems like the past, there's been water under the bridge, I've moved on, or I've moved back since that time. Since then it's reverted, there was some progress made then there's been a reversion.

After the experience of having engaged in a productive discussion with others in the reception meeting, the 'reality' of his detention in the Unit was underlined for Peter. When asked if there was anything that might have helped him to maintain this sense of progress subsequent to the reception meeting, he responded, *"To have not stayed. ...The others left and I stayed"*.

Colgan McCarthy (1994, p.128) argues that postmodern approaches to practice which aspire towards engagement with diversity and polyphony must also incorporate awareness of power and privilege, that *"stories stand in relation to other stories and that some are privileged while others are not. 'The haves' and 'the have nots' do not meet across equal thresholds"*. Ethical postmodern practice requires the adoption of a stance which both acknowledges that we live in social worlds which are constituted of multiple and diverse voices and stories, but also that some stories have consequences and that some of these stories have greater influence than others in organizing relationships. In other words, a socially constructed reality is still a 'reality' which has to be engaged with (McNamee 2003), and a locked hospital door is a text with a compelling message.

Navigating between conversational contexts or domains

In considering how practitioners might create space for dialogical practices in an overall service context which is orientated towards social control as well as therapeutic activities, the ideas of Lang, Little and Cronen (1990) are helpful. Drawing upon the work of the Chilean biologist and constructivist philosopher Humberto Maturana, these authors differentiate between what they term different socially constructed domains of professional practice, which they describe as a 'domain of production' and a 'domain of explanation'. These authors suggest that participation in each of these domains requires different moral commitments of the professional. The domain of production requires engagement with the taken-for-granted assumptions of the wider social order; it is a domain in which ideas of right and wrong, cause and effect, investigative procedures, and so on, are operational. Within the domain of production, the criteria and procedures for making judgements and for 'correct' action are often well established. In other words, this is the domain in which psychiatric professionals most frequently operate when discharging activities such as identifying pathology, assessing and managing risk; and so on. McAdam & Hannah (1991, p. 221) describe this domain in the following way:

"Within the domain of production, society develops laws and conventions which professionals are in the position of interpreting and enforcing... We become part of society's social controllers. We have the curiosity of an investigator, trying to discover if criteria for further action have been met or not. We do not have to have consent to work, although it is obviously preferable. We operate as if there was objective reality and as if truth exists".

Domain of production concerns were extremely pressing within the culture of the research site, with activities such as managing risk by undertaking 'observations' on service-users being identified by members of nursing staff from the Unit as being of the highest priority.

By contrast with the domain of production, in the domain of explanation multiple stories can co-exist and be elaborated by participants. This is the domain usually associated with the activity of psychotherapy. McAdam & Hannah again:

"In this domain we must have consent- if we act without it, we do violence. We operate with multiple realities and take all views as valid. We have the curiosity of an explorer or discoverer, creating a map for others and ourselves as we go... " (1991, p. 221).

It is this conversational domain which the reception meeting team aimed to create when hosting the meetings, a domain where new meanings and understandings could be co-produced by participants through dialogue.

In addition to the domains of production and explanation, Lang, Little and Cronen (1990) also conceive of a third 'domain of aesthetics', which is concerned with the ethical dimension of practice and with how activities can be undertaken in a manner which is aesthetic, elegant and moral, (for instance, in such a way that there is a recursive relationship between theory, practice and ethics in any given situation). The domain of aesthetics is overarching in the sense that it is this domain which informs the actions of the systemic professional when practicing in both the domain of production and the domain of explanation.

Amongst the criteria for acting aesthetically is the requirement to be very clear as a professional regarding whether one is practicing in the domain of production or explanation at any particular moment. McAdam and Hannah (1991) suggest that this

clarity from professionals regarding which conversational domain they are operating in is crucial since it significantly alters the definition of the relationship between the service-user and professional. Failure to achieve clarity about this may therefore result in the service-user feeling angry, dis-respected or even abused if it is subtly implied through the actions and manner of the professional that a conversation is occurring in the domain of explanation which is collaborative and heterarchical, when the professional is actually approaching the encounter in a monological and evaluative manner, for instance by drawing upon the content of the conversation to formulate an 'assessment' of the person's mental state. Applying this concept to the reception meetings highlights the importance of the staff who are 'facilitating' or 'hosting' such meetings being specific and 'transparent' with participants about power; about what issues can and can not be decided in the meeting. By clarifying what aspects of a situation are a 'given', it also becomes clearer about where space exists for negotiation, the expression of difference and for dialogue.

Practicing aesthetically by clarifying which domain of action an episode of interaction is occurring in is not a simple task, however. Data concerning participants experiences of the early part of the reception meetings suggests that there was considerable uncertainty regarding what kind of 'language game' they were entering into, and what the 'rules' for participation were. Participants were initially unclear, for instance, whether the conversations that would occur would be relatively straightforward with a focus on people being introduced to one another; or if the reception meeting would be a planning meeting similar in style to Care Programme Approach meetings or medical ward rounds; or alternatively, whether the reception meetings would be a kind of psychotherapy session in which relationships were explored in depth.

This degree of uncertainty may have been amplified by the kind of 'opening remarks' that the reception meeting team members tended to make when hosting the meetings, which may not have sufficiently addressed the question of what kind of conversational domain the reception meeting team aspired to create in the meeting, and what the contextual constraints on this process were. These opening remarks from members of the reception meeting team tended to be rather minimal, along the lines that the reception meeting had no pre-arranged agenda, and it was an opportunity for those present to discuss any concerns (Reed 1999). The rationale for this approach was that the team wished to avoid being over-influential or impositional regarding the direction that the discussion would take, as this might stifle dialogue by distracting from the immediate concerns of the service-user and family members, whose voices might already be

constrained in a meeting occurring on 'professional territory'. However, as Burnham has commented, it is as important to name what we wish to create as it is to name what we wish to avoid creating in systemic meetings (John Burnham, personal communication 1998). Similarly, Andersen (1998), drawing upon Wittgenstein's work, argues that people encounter problems when they are unclear about 'how to go on' in a particular set of circumstances. The early stages of reception meetings appear to have been frequently experienced as a context where there was initial uncertainty about how those present should 'go on' together, an uncertainty which appeared to relate to 'what kind of meeting this is', or as Helen, one of the professionals who participated in the research commented, *"it's a case of, em, "is this the right place for me to bring this up?"*.

These experiences of uncertainty discussed by participants in the research might invite the conclusion that members of the reception meeting were over vague or insufficiently detailed in the form of words that they used to open the discussions in the reception meetings, and that the aims of the meetings should have been stated in greater detail and with more clarity. An alternative interpretation of this data, however, and a one perhaps more congruent with a social constructionist practice, concerns the value of 'slowing down' the conversations that occurred in the initial phase of the meetings, and creating more space for careful negotiation of the purpose of the meeting, the different hopes, fears and expectations of those present, and the possibilities for how the people attending might 'go on together' in that context. In other words, rather than attempting to address uncertainties by introducing a more tightly scripted narrative regarding how the meetings should be used and thus risking a reduction in opportunities for different forms of joint action (McNamee 2003), more detailed attention might be paid to how participants might talk together and regarding the construction of a context where 'clarity' was an accomplishment of the group rather than being imposed by the professionals who were present. Andrews et al. (2000, pp. 142-143) in their account of power relationships in family therapy meetings raise a similar point about the importance of engaging flexibly in careful negotiations with families about how the meeting should be used:

"We find that the form of our meetings has become diverse, just as the families we meet are diverse. We have a sense now that these first negotiations about the structure of our meeting is our work with a family, every bit as much as later talk about problems and solutions. Indeed these first discussions seem to be a way of establishing the authority of family members which enables later talk of problems and solutions to be owned in partnership between staff and family".

Discourses of coercion and discourses of care often become blurred in psychiatric settings (Szasz 2000) where 'treatments' such as medication can be forcibly administered by staff on the grounds that a service-user is too 'ill' to understand the need for 'compliance', for instance. In a context where such blurring of conversational domains is fairly commonplace, participants might also be wary of taking at 'face value' the opening remarks made by members of the reception meeting team and might instead choose to observe for themselves what kind of discussions unfold in the reception meetings. Whatever the factors that were contributing to the high levels of uncertainty experienced by participants, data from the study suggested to me as a practitioner that closer attention to orientating and context setting remarks, and more particularly, to engaging in careful negotiations regarding conversational domains, (including, for instance, what kinds of decisions could be taken within the meeting, and what the limits of this were), might serve to enhance the conditions for dialogue within network meetings in a psychiatric context of this sort, for professionals as well as for service-users and their relatives.

While it is ironic, it is not surprising that attempts by the reception meeting team to avoid an impositional style of working in the hope of promoting dialogue appeared at times to enhance feelings of uncertainty, potentially stifling the voices of participants. Andrews et al. (2000, pp. 139-140) contend that it is a feature of our linguistically constructed realities that our attempts to resolve a particular problem or dichotomy tend to break down in this way:

"The general story of deconstruction is the attempt to erase an oppressive element of discourse, only to discover that element reappearing in different dress to frustrate the 'solution'. We will not be dismayed by this difficulty, but will regard it as constitutive of language as a social event which can never encompass all-there-is".

The challenge facing practitioners who aspire to postmodern, dialogical forms of practice is therefore not so much to develop ways of working which bear no traces of

oppression, where the 'problem' of power' has finally been 'cracked', but to develop strategies that enhance reflexivity. Or, as Vivian-Byrne (2001, p. 115) phrases the matter, we should encourage ourselves as practitioners within psychiatric organizations to *"create a contextual space within which we have room for manoeuvre in our task and can reflect on our motivations and actions"*. This reflective space should also include considerations of our own inevitable complicity with dominant narratives and associated practices of power.

Constructing a context of safe uncertainty

Mason (1993) suggests that an ethos of 'safe uncertainty' is required for dialogue to occur. According to this view it is important for practitioners to attend to factors which create a sense of sufficient emotional safety or 'containment' in meetings so that participants don't move into a position of 'unsafe certainty' which might be characterized by attempts to establish the 'truth' of one particular perspective and attempt to impose over-simplistic 'solutions'. Alternatively, a position of 'unsafe uncertainty' may lead participants to spiral into confusion and panic. When relating from positions of 'safe certainty' or 'unsafe uncertainty', it is unlikely that new learning will occur for participants as their capacity for listening and speaking reflectively will be impeded.

Data which were discussed earlier regarding participants experiences of uncertainty in the early stages of the reception meetings therefore carry potential implications for the meetings as forums in which dialogue could occur. If an experience of uncertainty reaches a point where it is no longer tolerable to individuals, they might retreat into the security of a monological, 'safe certainty' position. There are multiple factors which potentially mitigated against the creation of a sense of 'safe uncertainty' being co-created in the reception meetings:

- Hospitals are potentially intimidating places with customs and practices which are often alien to service-users and families (Rose 1985).
- The power invested in staff may further exacerbate feelings of anxiety and threat. Fears such as that the service-user might be *"kept in for life"*, as discussed by one of the participants in this study, may have acted as powerful inhibitors to open dialogue.

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- Interpersonal tensions and fears about conflict between family members might also provoke feelings of anxiety, as described by some research participants.

- Differences in perspective between the service-user, family members and staff may also be a source of potential conflict as well as of creativity.

In addition, because dialogical conversations are themselves unpredictable in nature, or to use Bakhtin's term, 'unfinalizable' (Trimble 2002), participants in the reception meetings might at times be drawn towards the experience of certainty associated with monological forms of communication. Discussing therapeutic conversations, Trimble (2002, p. 276) comments:

"In therapeutic conversations, we often find people caught in a dilemma: Because they have been wounded in some way, they are understandably fearful of the inherent confusion and unpredictability of dialogue, and seek safety in the order and certainty of monological constructions of themselves and their situations. Once established in monological positions, however, they become cut off from emergent, not-yet-spoken possibilities for action. Their relationships become thin as they engage only with others who support their monological positions, resisting those who contradict them and avoiding those who are open to seeing things in new and unexpected ways".

Monologue can therefore be characterized as a retreat from dialogue. Trimble's account of the impoverishing consequences for individuals of becoming fixed in monological positions bears a strong resemblance to Scott's account of the impact of interpersonal 'closure' on a person's life and relationships (Scott 1973). According to Scott, it is when traditional psychiatric narratives regarding 'mental illness' are invoked that the person's life becomes characterized by stasis:

'Closure can be a point of no return. . A symptom.... represents a partial death of that person as a social being. Being in the psychiatric space makes this death official' (Scott & Starr 1981, p. 183).

The task facing members of the reception meeting team in attempting to host meetings in which participants experienced a sufficient degree of safety to speak openly and engage in a dialogical conversation was therefore an extremely complex one. For service-users and their significant others who are attempting to make sense of the experience of hospitalization as well as the crisis which led to admission in the first place, the certainties of a monological position in which there is a single, accurate

account of the situation and in which the professionals are the 'Experts' to be deferred to might be experienced as preferable to the uncertainties of a more exploratory, dialogical position. In addition, the psychological and social hazards which Scott and Trimble have argued are associated with adopting this monological position of 'certainty' may become apparent over time, rather than being obvious from the outset.

Despite the difficulties involved in attempting to create space for dialogical encounters in the fraught environment of a psychiatric hospital, the stories told by participants in this research attest that a number of people experienced the meetings as a forum in which they could speak and be heard. As previously noted, several of the participants spoke about experiencing huge anxieties during the early stages of the reception meetings, but it is important to emphasize that for most participants these anxieties tended to subside during the course of the meeting.

Professionals experiences of safety and uncertainty

According to Bakhtin, dialogue is polyphonic in nature. The term 'polyphonic' was used by Bakhtin to describe the novels of Dostoevsky, in which the author and the characters within the story interact on equal terms (Morris 1994). Understanding is not located in the author or narrator, it is always partial and develops through the dialogical interaction between the different voices of those who people the novel, (including that of the writer). Generating dialogue in network meetings therefore entails the creation of a context in which the multiple voices and languages of participants who occupy different social positions can engage with one another. For staff hosting the reception meetings this required attending to the experiences and perspectives of other professionals in the meetings, as well as considering the service-user and their relatives or significant others. Tolerating the uncertainty associated with dialogue was potentially anxiety-provoking for staff as well as service-users and families, of course, since this position conflicts with professional discourses about being knowledgeable or demonstrating competence by 'having the answers' (Reed 1999). In the reception meetings professionals were in effect being invited to shift away from a position in which their account of the situation was elevated through the authority invested in their professional status and towards a potentially more vulnerable position where they were accepting personal responsibility for the views they expressed. Patterson (cited in Seikkula, 1995) states that vulnerability is associated

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with dialogue, in the sense that the participants in dialogical communication are open and exposed to one another.

Data presented earlier regarding the participation of professionals in the reception meetings suggests that the ethos of the reception meetings was at times experienced as challenging, (see chapter 7). There was more than one occasion, for instance, in which visiting professionals contacted members of the reception meeting team after a meeting to question the reliability of the service-users contribution in the reception meeting. For the professionals concerned, the absence of an opportunity to speak with the reception meeting team outside of the meetings without the service-user present may have been experienced as over-unusual, as compared to the professional practices that they were accustomed to. In choosing to avoid engaging in professional discussions before or after the reception meetings, the reception meeting team had been influenced by Seikkula's (1993) argument that this might impede the process of dialogue in the meetings themselves (Reed, Stevenson & Wilson 1998). For some of the professionals who attended, however, the rationale for approaching the meetings in this way may have been unclear or puzzling, as several of the research participants who were mental health professionals suggested they would have valued receiving more information prior to the meeting.

Nurses from the team that staffed the research site also described difficulties and tensions which were raised for them when participating in the reception meetings, particularly on occasions when they were attending the meetings as a 'ward representative'. Engaging in a dialogical process may have been difficult for staff who attended the meetings in this role for several reasons. A member of staff acting as 'ward representative' may not have had any previous direct contact with the service-user and their significant others, and might therefore have felt unable to offer a personal perspective on the topics under discussion. Colin, a nurse, commented, *"the uncomfortable bits were when I thought I shouldn't have been there because I didn't know what's going on, when I didn't have knowledge of the client"*. Colin also spoke about the frustrations and sense of restriction associated with *"reciting"* the views of others rather than contributing a personal opinion. Staff acting as 'ward representatives' may therefore have felt caught at times between conflicting sets of expectations: the expectations of the team that they were 'representing' that they would act as a conduit for the views of others, as a vehicle for passing on and receiving information within the meeting as against the expectations of the reception meeting team that they would participate in a dialogical process. In addition, dialogical conversation is essentially

spontaneous and unpredictable, and requires of participants that they tolerate a degree of risk, of being taken by surprise. It is a process which is outside of the control of any one participant. Staff acting as 'ward representatives' might therefore potentially feel rather exposed in this situation.

For less experienced staff, anxieties associated with the differing expectations that were at times in play within reception meetings might also have been amplified because they were likely to have had little prior experience or training in family and network-based approaches. Within the Finnish social network approach in Western Lapland, which provided the inspiration for the reception meetings, considerable attention and resources were committed to staff training during the early phase of implementing the network meetings as a routine aspect of service delivery (Seikkula, Alakare and Aaltonen 2000). By contrast, staff working in psychiatric in-patient settings in the UK tend to have limited access to training opportunities (Mansell and Malik 2000). Those colleagues working in the research site were therefore practicing in a context where training was difficult to access, and were to some extent 'thrown in at the deep end' in the reception meeting compared with their Finnish counterparts. This key issue of staff training and preparation for working in social network meetings will be further discussed in chapter 12, which considers organizational development issues arising from the research.

In the face of the dilemmas that staff faced when participating in the reception meetings, it would have been understandable if some had avoided attending them for fear of being 'put on the spot' or 'losing face' because of their lack of knowledge of the service-user's situation or of what might be expected of them in the meeting from the others who were present. A lack of knowledge is more likely to be made public in a context where the discussion is more spontaneous and unplanned than in the more scripted and task-orientated planning meetings that more frequently occurred in the research site. Several of the professionals who participated in the research commented that they would have preferred a clearer 'agenda' for the meeting, suggesting that it is important for practitioners who are hosting network meetings in this type of organizational context to hold in mind the potential anxieties and expectations of all participants, (service-users, their significant others, visiting professionals and members of the hospital team), and to attempt balancing the degree of structure / lack of structure within the meeting against these different concerns.

At the same time, it is important to hold in mind that facilitating a social network is a complex task, since the different participants are likely to attend with their own

individual expectations, hopes and concerns, and it may therefore not always be possible to negotiate a position where everyone's position and preferences are equally accommodated. Anderson (2002, p. 280) comments on the challenges facing the practitioner working in these forums:

"...a family or a social network system does not have an understanding or a language, rather each member has their own. The therapist is always working within a polyvocality. The challenge becomes how to invite and maintain room for each voice and in a way that the descriptions and opinions develop into the joint process or in my experience a joint storytelling process".

Considering the notion of the 'domain of aesthetics' as a framework for shaping practice (Lang, Little & Cronen 1990), in the face of a dilemma about how to attend to conflicting expectations regarding what should occur in a network meeting, responding more fully to the preferences of the service-user in favour of those of others present such as members of the professional network seems a justifiable ethical stance for practitioners to adopt. A hospitalized service-user occupies a relatively powerless position within the system when contrasted with that of the others who are present, and it is therefore crucial that opportunities are maximized for his or her voice to be heard. The importance of attending carefully to the language and perspective of the service-user has been underlined by a number of authors writing about the practice of facilitating network meetings (Anderson 2002; Seikkula 2002; Trimble 2002).

Summary of key practice-based 'findings' or themes generated through the research

In this thesis I have developed a range of narrative accounts which I hope will be of interest to practitioners who also wish to adopt a systemic and social constructionist informed approach to practice in similar settings. These different stories about practice are presented with the aim of creating richer descriptions regarding practice possibilities within these complex agency settings. The narratives are offered, then, in a spirit of dialogue, as possibilities which practitioners might hold in mind and adapt, develop or use selectively, according to the specificities of their own practice contexts.

The key practice-related narratives or 'findings' that have been developed through the research are summarized below:

Narratives regarding contextual factors

- Acute admissions units are characterized by a tension between therapeutic and risk / crisis management control' functions. There are multiple constraints, associated with institutional, cultural and resource-based factors, which can be dis-empowering and even, at times, de-humanizing for staff and service-users in this kind of environment. In addition, the elevation of the 'objective' medical voice in hospital settings represents a challenge to polyphony.

- Despite these asymmetries of power and cultural constraints, reception meetings provided a vehicle in which opportunities were created for service-users, family members and staff to engage in more collaborative and dialogical patterns of communication. Such meetings therefore offer an opportunity to reduce the potential for interpersonal 'closure' to occur (Scott & Ashworth 1967).

Narratives regarding experiences in the reception meetings

- While two family members expressed reservations about the group format of the meetings which they experienced as inhibiting, the majority of participants felt that this offered opportunities for enhancing relationships by 'bringing people together', psychologically as well as physically.

- Bringing people together in this way also appeared to create a dialogical space which offered the possibility of people talking together about potentially fraught issues without conflict ensuing.

- Initially, participants said that they had experienced high levels of uncertainty regarding what to expect in the reception meetings. This uncertainty was experienced by most participants, regardless of the different social positions they occupied within the research site (service-users, family members or staff). Confusion regarding the kind of language game that was occurring, and about what the unspoken 'rules of participation' in the meeting were, frequently ensued.

- For some service-users this uncertainty was also, however, accompanied by a sense of opportunity. The relatively unstructured style of the reception meetings appeared to be particularly important in allowing opportunities for participants to 'find' their voices and to speak of matters which were previously unsaid or unheard by others.

Narratives regarding postmodern professional practice

- The presence of reception team members, and their style of participation in the meetings was valued by several participants for qualities of "gentleness", "quietness" and "informality".

- The manner in which team members attended to multiple points of view and facilitated conversational flow within the meetings was also discussed in positive terms by service-users and family members in the study.

- Reflective conversations of the type developed by Andersen (1990) were valued by some participants as these conversations provided opportunities for family members to be present in the discussion by listening without feeling pressurized. At times, however, the reflecting discussions were also experienced as distancing.

- Staff hosting reception meetings are reliant upon a sensitivity towards the immediate relational context, or, what Shotter (1993) describes as 'knowledge of the third kind', in guiding decisions regarding whether to utilize approaches such as Andersen's (1990) reflective discussions in reception meetings.

- When network meetings occur in hospital settings, the staff hosting them should also be aware of the high levels of uncertainty which might initially be experienced by participants. If dialogue is to occur, an ethos of 'safe uncertainty' (rather than 'unsafe uncertainty' or 'safe certainty') is required (Mason 1993).

- Since a blurring of discourses of 'care' and discourses of 'control' often occurs in psychiatric hospital settings, one of the ways that staff can facilitate an ethos of safe uncertainty is by articulating the particular conversational domain that

participants are operating within in a given moment, so that participants are clear about what are the 'givens' or non-negotiable aspects of the situation (for example, the 'reality' of detention under Mental Health Act (1983) legislation), and which areas are open to exploration and re-negotiation (Lang, Little & Cronen 1990).

- The dominance of the bio-medical discourse within psychiatry, and the perceived allegiance of psychiatrists with this discourse, can contribute towards stereotypical expectations from other, non-medical participants regarding the contribution of doctors within reception meetings. Some participants in this study, felt that the presence of doctors would lead to narrow, monological discussions prevailing in the meetings and that it was preferable for medical staff not to attend. One participant, however, felt that the meeting she attended had little value because a doctor was not present, and medical issues were not included in the discussion that occurred. This raises particular issues for practitioners to consider in relation to the practice of convening network meetings, and whether to attempt to convene all those who are participating in the 'problem-determined system', as Seikkula (2002) recommends, or whether to be primarily guided by the wishes and preferences of the service-users, in view of the dis-empowered position they occupy within this particular social field.

Personal responses to the 'findings'

Since practitioner research offers an opportunity for the practitioner to re-view and extend his or her own assumptions and prejudices (Andersen 1993), it is appropriate for me to comment on some of my own responses to the themes summarized above. In particular, I wish to discuss those 'findings' which created the most surprise for me, since as Schon (1987) has commented, it is through the process of reflecting upon surprising occurrences that our practice develops.

Much of the data generated through the research was very affirming to me in relation to my beliefs about practice. The accounts provided by participants regarding their experiences of voice, of feeling able to speak and feeling that they were listened to within the reception meetings confirmed for me the value of developing this type of service within hospital settings. Important conversations had occurred in the meetings

for several people. I did, however, experience surprise in relation to the levels of uncertainty experienced by the majority of participants during the early stages of the meetings. I anticipated that people might feel unsure and uncomfortable to begin with, but for some participants the experience seemed to be close to overwhelming. A number of people suggested that they would have liked more information in advance of the reception meetings, or more of an 'agenda' for the discussion. Hearing these comments as a practitioner researcher I felt rather puzzled, as my own experiences within these meetings was that members of the reception meeting team had given a brief but adequate account of what the purpose of the meetings were, (these comments were deliberately kept brief, to avoid being over prescriptive). The degree to which the unstructured format of the reception meetings was experienced as frighteningly strange in a context where more goal-orientated, instrumental or interventive approaches are more usual was therefore an important 'discovery' for me, and stimulated many reflections regarding the importance of taking time and care over the negotiations that occur during the early phase of a network meeting.

I have also gained through the research process a richer understanding of the experiences of professional colleagues, particularly those working specifically within the hospital. Although I have worked in a range of mental health settings over the course of my career, this has been primarily in community-based services or in specialist residential settings that were well resourced by comparison with the circumstances that these staff were facing. I was well aware that these colleagues were working under pressurized circumstances, but hadn't fully appreciated how challenging the prospect of participating in a dialogically orientated network meeting might be. Colleagues attending these meetings in the role of a 'ward representative' might have had no prior first hand contact with the service-user, but felt that they were entering a situation where they would be expected to offer an opinion or view of the situation. Other duties within the Unit such as undertaking 'observations', which might require less personal participation, might well have been viewed as a less threatening, and therefore preferable, type of activity to engage in. Within the reception meeting team we tended to avoid engaging in discussions prior to the meeting with the other professionals who were attending, to discourage a professionally-determined focus or agenda being created in advance. The themes developed through this research indicate to me, however, that this position is in danger of underestimating the degree of anxiety that colleagues might be experiencing, and that the option of providing an opportunity to talk about how they might contribute to the meeting, (rather than about the service-users situation), might therefore be facilitative.

Identification of implications for practice development was a key aim of this research, and the discussion in this chapter has therefore focused primarily upon the specific 'micro-processes' of practice. In the chapter that follows, the scope of the discussion will be broadened by locating the practice implications arising from this study in relation to a range of wider contexts. Connections will be drawn between the key messages arising from this study and contemporary trends within the areas of government policy; service development; professional training; and finally, with the field of practice-based research

Chapter 12. 'Bigger pictures': Connecting the study with broader trends in policy, service development, professional training and practice-based research.

The discussion in this chapter shifts from being primarily concerned with direct practice-based concerns by connecting the themes that have been highlighted in the study with a range of broader contexts that hold relevance for the implementation of network-based approaches in psychiatric settings. Firstly, I will consider the significance of recent government policy initiatives, arguing that the general thrust of policy towards the inclusion of families and carers in the planning, delivery and evaluation of mental health services (Dept. of Health 1999a) provides a broadly supportive climate for the implementation of family and network approaches. Despite these encouraging developments at the level of policy, however, mental health practitioners attempting to introduce new services for families in hospital settings may continue to encounter significant organizational barriers, as data presented in previous chapters of this thesis attests. I will therefore go on to explore some of the service development issues arising from the study, including a consideration of the professional support and training required by staff working in these contexts. Finally, I will identify connections between key themes arising from this study and the broader field of practice-based research, highlighting areas of inquiry that were identified but not fully addressed in this study because they fell outside of the scope and design of the research.

Connections with recent policy directives

Government policy over the past decade has increasingly emphasized the importance of psychiatric service providers recognizing the contribution of families and carers in supporting people who are identified as 'mentally ill'. The Care Programme Approach (Dept. of Health 1996) sought to improve the coordination of services by including carers in the planning, monitoring and evaluation of care packages. The National Service Framework (NSF) for mental health (Dept. of Health 1999a) further emphasized the contribution of families and other carers by requiring service-providers to seek their views, provide information on the help that is available to them, and also to explain to carers their right to request an assessment of their own needs. The NSF also stresses the value of involving carers in the planning and development of mental health services. In

addition, the right to an assessment of carers needs came into force as part of the Government's national strategy for carers (Dept. of Health 1999d).

New developments in policy are not accompanied by immediate shifts in practice however, and complex implementation issues need to be addressed within hard-pressed mental health services which are struggling with limited resources as well as the constraining legacies of reductionist thinking and institutional practices (Hunter 2002). Increasingly, government attention has therefore been directed towards service development and the promotion and implementation of 'best practice' (Dept. of Health 2002).

A literature review and consultation exercise regarding services for carers of people with mental health difficulties that was commissioned by a Department of Health funded body, the National Co-ordinating Centre for NHS Delivery and Organisation Research and Development, concluded that effective services for carers should be underpinned by four principles: that services should be positive and inclusive; flexible and individualised; integrated and coordinated; and accessible and responsive (NCCSDO 2000). These principles were, according to the report's authors, based on a consensus view that emerged from the consultation process with carers. The aspirations, aims and procedures associated with the reception meetings were highly congruent with the four principles articulated by the NCCSDO:

- **Positive and inclusive.** The NCCSDO (2002, p.2) briefing paper which summarizes the key 'findings' of the consultation process states *"mental health professionals should have a positive approach to carers, involve them in decision making and recognize them as 'partners' or 'co-experts'"*. This principle of inclusiveness resonates strongly with the primary aim of the reception meetings regarding the creation of a forum in which collaborative, dialogical conversations could occur between service-users, families and professionals.
- **Flexible and individualised.** The principle that services should reflect the diversity of carers rather than delivered in a standardised manner is also highly congruent with the reception meeting team's aspiration that the meetings should be tailored to the concerns of those present, rather than becoming formulaic or following a professionally-determined agenda.

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- **Integrated and coordinated.** The principle of well coordinated, 'joined up' services was also integral to the systemic ethos of the reception meetings, which sought to bring together staff from different professional disciplines, as well as from hospital and community-based settings, to join with the service-user and family in open dialogue.

- **Accessible and responsive.** Again, this principle dovetails with the reception meeting teams aspiration that meetings should occur as soon as possible following a person entering hospital, so that a dialogical process could be initiated from the outset and the processes of interpersonal 'closure' that can ensue between the service-user and their family in these circumstances might be minimized.

These principles regarding how mental health care should be delivered which were articulated by the families and carers who participated in the NCCSDO consultation process may appear rather uncontentious. However, data presented in previous chapters of this thesis highlights the implementation difficulties associated with introducing into routine psychiatric practice a new service which was highly congruent with these principles. Attempts to establish the reception meetings as a responsive service that was available to all service-users and occurred rapidly following admission were frequently hampered by factors such as inadequate staffing levels and a cultural orientation towards risk assessment rather than therapeutic engagement. Despite these obstacles, however, practitioners who wish to introduce family and network-based approaches in contemporary psychiatric settings can find broad support from recent policy initiatives, which aim to steer services towards more inclusive and 'family friendly' practices.

The vocabulary of mental health policy

Prior to moving from a consideration of the current policy context towards discussing the organizational development issues that were highlighted by this research, it is important to add a word about the language and terminology employed in recent policy documents. Johnstone (2001), a staunch critic of medical psychiatry, introduces a note of caution regarding an over-enthusiastic welcoming of policy initiatives such as the NSF (Dept. of Health 1999a). She argues that while there is much to recommend the NSF in terms of its emphasis on principles such as inclusivity, the document is flawed by its unquestioning assumption of a biomedical model of distress. The vocabulary of the medical model permeates the NSF, according to Johnstone, and will therefore inevitably

influence the planning and delivery of future services. She therefore predicts rather gloomily that the centrality of these biomedical assumptions within the document will result in a situation where, *"all the faults of the old system will be carried through into the new one"* (2001, p. 2). Based upon such a reading of the NSF, one might conclude that it carries mixed implications for the development of services such as the reception meetings; while the principle of greater inclusivity might support the implementation of family and network orientated practices, for instance, the reinforcement of unexamined biomedical assumptions might create a less fertile context for systemic practice approaches which embrace multiple voices and an appreciation of the socially and culturally specific nature of knowledge and understanding.

Practitioners in the UK who aspire to implement family or network-based approaches within adult psychiatric agencies will find broad support for their argument from recent UK policy documents which emphasis service collaboration with families and carers. The case for introducing these approaches can be specifically linked with themes within the NSF, for instance, which requires user and carer involvement in services. Developing a case for network meetings upon theoretical rather than pragmatic grounds might prove to be a less successful strategy however, since the potential tensions between a systemically-orientated approach and the reductionism that Johnstone (2001) suggests is implicit in the NSF document may be foregrounded. In the discussion that follows, organizational development issues will be explored in further detail and some specific strategies for promoting family and network approaches will be considered.

Connections with service development agendas

One of the most frustrating, but also fascinating aspects of the practitioner research process in this study related to the level of difficulty experienced by myself and my colleagues in the reception meeting team in attempting to introduce this new service development within the research site. In retrospect, there was a level of naivety associated with the early team planning meetings which may have resulted in us being less strategic and systematic in our thinking than we might have been if we had been fully cognizant of the barriers that we would meet on the way. As noted previously, (see chapter 2), these barriers were not specific to the local circumstances of the research site, and implementation difficulties associated with introducing family-orientated approaches into routine psychiatric practice have been highlighted in the previous literature (Fadden 1997; Smith & Velleman 2002; Wright 1997). The nature of the

organizational barriers that were encountered within the research site will now be re-visited, and linkages will be developed with different service development strategies which have been proposed in the relevant literature.

Cultural constraints upon engagement with families

Smith & Velleman (2002) have cited the orientation towards crisis management that is characteristic of acute admissions units as a major barrier to the routine implementation of services for families, and this was one of the major difficulties encountered in introducing the reception meetings within the research site. Resource constraints and an associated emphasis on crisis management at the expense of planned interventions created for staff an orientation towards the immediate and a sense of fluctuating priorities according to shifting circumstances. Under these service conditions, engaging in more reflective forms of practice can present a major challenge for practitioners (Hawkes, Hopkins & Reed 2001). Ironically, this emphasis on responding to immediate crises and risk-management to the detriment of more conversational and contextually sensitive approaches may create a set of conditions in which service-users feel that their concerns are not heard as staff struggle to find the time and psychological 'space' to talk with them, resulting in greater anxiety and therefore an increased likelihood of crises erupting. A vicious cycle may therefore become operant in which, to draw upon a key tenet of early systemic practice, the 'attempted solution serves to maintain the problem' (Dallos & Draper 2000).

A further barrier to the implementation of family and network approaches associated with the crisis orientated culture of acute admissions units is that what Hudson (1995) refers to as a 'responsibility vacuum' can develop. This phenomenon was exemplified in the words of a member of the nursing team within the research site, who in relation to arranging reception meetings commented, *"It's not my job, it's the primary nurse's job, and she's on holiday!"* . If staff are focused primarily upon the immediate tasks which need to be addressed during a particular shift, complex and time-consuming activities such as convening network meetings which require advance negotiations and forward planning are less likely to be undertaken. A crisis orientated culture does not invite staff to maintain the kind of 'relationally engaged' approach associated with dialogical practice (McNamee 2003).

Attempts to link responsibility for convening the reception meetings with the primary nursing role were not particularly successful in the research site, in part as a consequence of the Unit being insufficiently resourced for the primary nursing system to run effectively. 'Fall back' systems such as having identified 'named nurses' and 'ward representatives' for the relatively frequent occasions when the primary nurse wasn't available also appeared to be unsuccessful in maintaining a sense of continuity across different shifts. The Finnish Open Dialogue approach developed by Seikkula and his colleagues (Seikkula et al. 1995) addresses this issue of responsibility for engaging the wider social network at the beginning of the treatment process by adopting a principle whereby the member of staff who receives the initial request for help carries subsequent responsibility for convening the first meeting. What can be surmised from data generated in this study, however, is that for such a system to be implemented successfully in the UK, the staff concerned will require organizational support in finding time and space within the day for potentially time consuming convening activities. In addition, it is important to keep in mind that most staff will have had little or no prior training in convening families and wider networks. The practicalities regarding how this issue of responsibility for initiating the network process when a person enters hospital can be most successfully addressed will inevitably vary in different agency contexts according to local circumstances, but practitioners who intend to introduce a family or network-based approach into a psychiatric hospital setting would be well advised to give careful thought to convening issues. This includes not only where responsibility lies, but also the provision of appropriate training to staff, an area that will be discussed in greater detail later in this chapter.

Promoting family and network approaches within psychiatric agencies

A key strategy proposed by Smith and Velleman (2002) for supporting the introduction of family-based services in adult psychiatry agencies is the identification of a 'service champion' within the organization. These authors argue that the service champion should occupy a senior role and report directly and regularly to the senior management body within the organization. Smith and Velleman contend that a service champion at this level can ensure that the implementation of these services is actively supported at all levels of the organization. Training, clinical supervision and other support systems for family-based approaches can then be prioritised and implemented across the service.

Within the research site the reception meetings were viewed positively by senior managers and clinicians, and there was a general sense of good will and a desire to see this interesting new service prosper. This level of support was evident in secondary data gathered for the study such as correspondence and minutes from Unit meetings, where the reception meetings were frequently alluded to in positive terms. There was, however, no formalized system for members of the reception meeting team to report to the senior management group, and similarly, no formally recognized 'service champion' who was responsible for managing the process. Instead, the different members of the reception meeting team attempted to act as 'ambassadors' for the new service in a relatively low key manner, by providing information to colleagues in the different clinical teams attached to the research site, organizing occasional training and information sharing sessions, and so on. This more 'grass roots' approach to service development was perhaps more consistent with the dialogical ethos of the reception meetings. In addition, Smith and Velleman (2002) are specifically concerned with the introduction of the medico-behavioural 'family management' approaches which are commonly regarded within psychiatric services as having an established evidence-base, a key issue within contemporary health care services (Muijen 2003). While there is some, albeit more limited, outcome-based 'evidence' supporting the application of systemic approaches in severe psychiatric disorder, this research is less widely known about and systemic therapies are consequently regarded by many as more experimental and therefore perhaps as less relevant (Johnstone 1999). The reception meeting team were therefore necessarily more reliant on attempting to generate enthusiasm and interest incrementally rather than adopting a more insistent or strident approach. To have done so may have been to risk the evaporation of the good will and support that was offered initially.

A more systematic and multi-pronged approach to implementation may, however, have achieved greater success in establishing the reception meetings as a routine feature within the research site. It is unlikely that relying entirely on a 'top down' approach to organizational change would be successful, as this may simply generate resentment amongst staff in more junior roles who can easily resist the process covertly if they are not persuaded of its value (Selvini Palazzoli 1984). At the same time, it is important that support is gained from senior figures within the organizational hierarchy, so that it is clear to staff that engaging in family and network meetings is a recognized and important aspect of their role, rather than a peripheral activity. As Bowles (2002) has noted, nursing staff on psychiatric awards are keenly aware of the organizational requirement that they undertake risk management activities such as 'special observations' as this aspect of their work is set out in organizational policy documents.

The requirement to engage in more reflective or therapeutic activities is not specified in the same way, however, and so hard-pressed staff will generally prioritise those activities which are required of them in order to preserve job security. If engaging in family–orientated practices such as the reception meetings are to be viewed as a 'core activity' amongst staff, then this message must be reinforced by managers and senior clinicians. Practitioners who are interested in developing abilities in working with families and social networks will then feel supported in doing so.

Connections with the field of professional training

The success of the Finnish social network approach appears to have been built upon an intensive and well resourced training programme which was accessed by all staff in the Western Lapland service. Seikkula, Alakare and Aaltonen (2000) state that all of the staff from the in-patient and outpatient teams attended either a three year family therapy training or training in another psychotherapeutic approach, and that 75% achieved qualification as psychotherapists under Finnish law. For practitioners in the UK, these figures are staggering. Training opportunities for staff in statutory mental health services in Britain tend to be modest, and practitioners in in-patient settings have tended to fare particularly badly in this respect (Mansell and Malik 2000). Within the research site, some members of the reception team had undertaken some post-qualifying training in systemic family therapy, and two people were registered with the United Kingdom Council for Psychotherapy (UKCP) as family psychotherapists[1]. The majority of staff within the wider team in the Unit had minimal prior training in family work or in other 'talking treatments', however. Any training strategy which is developed to support the implementation of network meetings in a UK psychiatric context must therefore take account of the 'realities' of limited funding, staff shortages and a workforce who are likely to have minimal prior knowledge of systemic or other psychotherapeutic treatment approaches.

Training for 'not knowing': postmodern dilemmas

Postmodern approaches to practice such as those associated with 'hosting' or 'facilitating' the reception meetings pose particularly complex dilemmas in relation to

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[1] The UKCP is a central body which registers psychotherapists within the UK and sets standards for training.

education and training. A social constructionist-informed practice is characterized by a philosophical orientation towards conversation, with the emphasis placed on responsive forms of relational engagement with others, rather than a specific model or body of techniques (McNamee 2003).

Within the family therapy field an increasing number of practitioners who are sympathetic towards postmodern and social constructionist ideas have expressed scepticism regarding a rejection of the importance of expertise and technique in working with families and wider systems (Burnham 1993; Mason 2002). Placing too great an emphasis on a 'non-expert', 'not knowing' conversational stance may, however, create a paradoxically mystifying effect, leaving professionals who are new to this way of working feeling confused, and suspecting that the knowledge and abilities that they perceive to be possessed by more experienced staff are simply being withheld from them. This dilemma was highlighted in comments by professionals who participated in this study regarding their uncertainty about how to 'go on' in what they experienced as the unfamiliar and unusual context of the reception meetings. Service-users and relatives who participated in this research frequently spoke of their experiences of the reception meetings in terms which suggested that the meetings had the quality of 'ordinary' social conversation. Despite the apparent simplicity of the activity, conversing in a relaxed and reflective manner within a social network meeting may be a daunting task for psychiatric staff who may have had minimal prior training or experience in working with families, and who may be more familiar with participating in fairly tightly-scripted and task orientated meetings where roles and expectations are more clearly specified from the outset.

User and carer perspectives in training

An important dimension to the general ethos of the reception meetings related to the composition of the team of staff who hosted or facilitated them. As discussed in chapter 3, the reception meeting team comprised workers with a range of personal and professional life experiences, including two staff members with direct family experience of caring for relatives who had received psychiatric in-patient treatment. The participation of these colleagues was an invaluable contribution to the range of perspectives available to the team, and potentially helped team members to become more sensitized and informed in relation to family members experiences of the psychiatric hospital system.

The contributions of people with direct experiences as users and relatives of psychiatric systems is potentially helpful in countering the development of a hegemony of professionally-based knowledge regarding how network meetings should operate. The training and preparation that psychiatric staff will receive for participation in social network approaches should therefore ideally include not only a focus on social constructionist ideas and approaches associated with the family systems field, but also contributions from service-users and family members. The inclusion of service-users and family members in the design, delivery and evaluation of a training programme would also be consistent with current trends in the qualifying-level training of mental health professionals (Sainsbury Centre for Mental Health 1997).

The discussion regarding professional training in this section is necessarily rather speculative and tentative, since the research was primarily concerned with the domain of practice rather than with education. The issues and themes that are raised here are therefore potentially fruitful topics for future research. In the section that follows, I will highlight some further connections between themes arising from the study and the broader field of practice-based research.

Connections with the wider field of practice-based research

Prior to exploring connections between themes raised in this study and trends in the field of practice-based research, I will briefly discuss more generally the contribution of research towards the development of practice-based disciplines, since there are multiple other approaches to enquiry and learning that can potentially be employed to extend knowledge in this area. Rolfe (2002), for instance, advocates literary fiction as a source of knowledge and 'truths' regarding human life and relationships that can deepen practitioners affective understanding of the dilemmas facing service-users. Eraut (1994) also challenges the concept of knowledge creation that places the academic researcher centre-stage, arguing that in professionally-based disciplines new knowledge is often developed by practitioners themselves from experiences in the field. This practitioner-developed knowledge is of a different sort to that created by researchers, Eraut contends, in that it is generally knowledge which is useful in informing practice and which is often fruitfully shared with colleagues, but which is not necessarily formalized, codified, and disseminated in the same way as research-derived knowledge. In addition, Eraut suggests that practitioners can help to extend and develop knowledge which is developed in academic contexts in important ways. He argues that knowledge creation

and knowledge use can not be clearly separated, since the use of a theory in a specific practice context is in itself a small but potentially crucial contribution to the development of that theory. In other words, the interpretive application of knowledge inevitably changes that knowledge in some way. Eraut goes on to recommend collaborative research projects between academics and practitioners which are focused upon the acquisition and extension of professional knowledge and abilities.

There is currently an encouraging level of support for practice-focused research approaches at government level, with the Department of Health's Research and Development Division expressing a commitment to the promotion of practice-based research that will lead to the development of improved services, and particularly recommending, *"rigorous qualitative research that encompasses the experiences and perspectives of carers, people with mental health problems and mental health professionals"* (NCCSDO 2002, p. 4). This increased regard for qualitative, practice-based research approaches is timely in view of the levels of concern that have been expressed in relation to adult acute psychiatric facilities, and the pressing need for change (Dept. of Health 1999b). The organizational constraints to practice development that were identified in this study, and which have also been highlighted in previous literature regarding the implementation of family based approaches in adult psychiatric settings, suggest that further collaborative and contextually-sensitive, practice-orientated studies are strongly recommended. Further inquiry into the organizational mechanisms that would sustain a family or network orientated service as a permanent feature of everyday organizational activity is therefore crucial.

Finally, returning to the theme of collaborative research approaches, there is an increasing appreciation within the mental health field of the value of studies that are undertaken in partnership with service-users and with family members. In relation to the evaluation of service delivery, Clark et al (1999, p. 961) have argued that when service-users, *"are not consulted about or involved in the design of satisfaction surveys, instruments may not ask important questions and may be biased towards the perspectives of the service provider"*. Similarly, Townend and Braithwaite (2002) also argue that service providers and service-users often have competing priorities, and call for service-user participation at all stages in the conduct of mental health research. These authors argue that service-users experience of distress and contact with services can enrich research in a way that would not otherwise be achieved. Extending this argument, Andrews et al (2000, p.144) have warned of the potential for research to function as a *"subjugation narrative"* if inquiry into practice occurs at, *"the expense of the right of*

family members to develop their own way of speaking of their lives". Since the primary aim of the reception meetings was to generate collaborative and dialogical communication between staff, service-users and family-members, it would be congruent with this aspiration if future research was developed on a partnership basis between individuals who occupied these different social positions.

Summary

The direction of government policy in relation to mental health care within the UK over the past decade has been broadly encouraging towards practice-approaches that are inclusive of families and wider networks, as well as towards more integrated patterns of inter-professional working (Dept. of Health 1999a). Services such as the reception meetings, that aspire to promote collaborative relationships between families and psychiatric staff as well as between different members of the relevant professional networks, (for instance, members of the hospital and community teams) are congruent with key themes that can be identified in policy documents such as the National Service Framework for mental health (Dept. of Health 1999a). At the same time, however, the biomedical vocabulary which Johnstone (2001) argues is uncritically employed in this key policy document may reinforce a reductionist service culture in which implementation difficulties persist in relation to family and network approaches.

Service development issues associated with the implementation of network approaches have therefore been examined in this chapter, with linkages identified between themes arising from this study and the previous literature in this area. Some potential service development and professional training strategies for furthering family and network approaches were explored and tentative proposals were offered.

In keeping with the postmodern methodological stance adopted for this research, I conceive of the ideas and suggestions that are discussed in this chapter as narrative accounts; as stories that might inform future practice and organizational development strategies. In other words, these stories are offered in a spirit of dialogue, in the hope that this might have practice utility for others working in broadly similar contexts, or that they might inspire further conversations and connections to be developed which promote practice and service development.

Chapter 13. Bringing it all back home.... Reflections on the research process

In undermining realist notions of 'objectivity', postmodernism invites a focus on reflexivity in the processes of knowledge creation. Koch and Harrington (1998) argue that the researcher should aspire towards 'transparency' regarding the decisions made along the way in designing, implementing and presenting a study. This openness allows the reader to understand something of the way in which the research account was constructed in a specific set of circumstances, so they can then make judgements about the plausibility and relevance of the story told through the research.

In the interests of reflexivity, this final chapter therefore centres upon my own reflections upon the research journey that I have undertaken to produce this thesis. This process of re-view will include a discussion of the appropriateness of having embraced postmodernism as a guiding methodological position for the activity of practitioner research in the first place, as well as reflections upon the practitioner research design itself and the opportunities and constraints that were afforded by it. This reflective discussion regarding the research methodology and methods therefore provides a context within which the nature and status of the narratives about practice that were developed in the previous chapters can be located and considered.

The adequacy of a postmodern methodology

Postmodernism as a philosophical movement has been pronounced dead by Baggini (2002), who argues that the scale of events when the World Trade Centre was destroyed on 11th September 2001 render an anti-realist position unsustainable. According to Baggini, the 'real broke through' at the moment of this attack in such a catastrophic way that any subsequent attempts to maintain an ironic distance from the concept of an objective reality would be both intellectually lazy and politically dangerous[1].

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[1]A different view is offered by Andersen (2002), however, who argues that in the wake of 11th September, a pluralist approach is even more essential. Andersen argues that the destruction that occurred on that date and from the subsequent military responses has been partially driven by a certainty on both sides that their world view represents the 'Truth'.

Returning to the less global, conflict-ridden arena of mental health practice, however, the value is postmodern thinking is also open to question. Notions of 'good practice' which influence government policy and service development planning are increasingly shaped by reference to the available 'evidence base', with large scale, random controlled trials being hailed as the most persuasive 'evidence' of all (Muijen 2003). In addition, the 'realities' of life in the UK can be harsh for users of mental health services, who are often subject to intense prejudice and discrimination, including verbal and physical harassment, reduced employment opportunities, and social marginalization (Sayce 1998). Minuchin (1991) has argued that the anti-realist position of postmodernist practitioners does not allow for robust ethical engagement with these injustices. Similarly, in relation to the field of physical health care it has been contended that postmodernism is an option only for the healthy, not for the sick (Fox 1999). In the face of extreme suffering or oppression the certainties of modernism might appear to represent a more viable framework for intervention than that provided by a postmodern preoccupation with language and story.

If postmodernism has died, however, then in the field of UK mental health care it was stillborn, since it was only 'truly present' in terms of the possibilities it held. Since postmodern theory is regarded, by some, as passé in philosophical circles, as largely irrelevant by policy makers who are concerned with the 'realities' of measurable performance outcomes, and as inadequate in addressing social injustice, then questions are raised about its value as a methodological framework for practitioner research.

In relation to this study, it is my contention that drawing upon postmodern ideas has conferred a range of important benefits and opportunities that a more positivist orientation would not have allowed for. Firstly, The 'incredulity towards metanarratives' that characterizes postmodernism (Lyotard 1992) invited me to engage with the multiple voices of service-users, family members and staff, rather than seeking a single, monological account regarding the value of the reception meetings as a service development. Positivism can be, as Bender (1998) comments, something of a 'conversation stopper', and a postmodern orientation facilitated engagement with a multiplicity of voices, rather than attributing 'Truth' status to any single perspective.

Similarly, the rejection of the belief that 'Truth' is established through rigorous application of appropriate method (Gergen 1985) allowed for an appreciation of the value of employing multiple methods as appropriate to the specific context and conditions of the research site (Denzin & Lincoln 1998). Utilizing multiple methods in

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this way helped to create a sense of 'binocular vision' (Bateson 1988), enhancing depth of perception.

In addition, rather than viewing my dual 'practitioner / researcher' roles as compromising the objectivity of the study, the postmodern emphasis on the socially constructed nature of knowledge allowed me to consider these different roles as enriching to the research process. This methodological position also brought into clearer focus for me my own participation in the process of knowledge construction. Adopting a postmodern position was facilitative in that it enabled me to stop worrying about the 'purity' of being a researcher who was also a practitioner in the research site.

Postmodern research in modernist contexts: Can a PhD be postmodern?

A central question examined in this research relates to the extent to which it is possible to successfully implement a practice development which has a postmodern orientation into an organizational setting with a strongly modernist culture. Similarly, in reflecting upon the process of designing, implementing and writing up this study, a further, related question is raised for me regarding the extent to which it has been, or might be, possible to undertake 'truly' postmodern research[2] when the context for the study is the production of a PhD thesis. Richardson (1990) discusses the manner in which the writing of an account is necessarily shaped by the particular audiences for whom the text is intended. Different styles or genres of writing are appropriate for different readerships, and the tale which is told therefore needs to be (re)cast accordingly. While this might be regarded as a rather superficial, stylistic issue, a social constructionist perspective requires us to recognize the relationship between the nature of a story told and the process of storytelling (Pearce & Pearce 1998). In other words, the manner in which the research is presented has implications for the content of the study, what aspects are emphasized or de-emphasized, included or omitted, and so on.

In relation to the production of this research, amongst the most significant audiences have been, of course, the wider academic community and those who would eventually examine the thesis. Writing with the Northumbria University regulations for PhD awards in mind has therefore inevitably fundamentally shaped both the structure and the content of the research. The process of attempting to undertake a reflective, exploratory inquiry

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[2] Pun intended, of course!

has occurred within a context of knowing that the work will eventually be evaluated against particular criteria for acceptability. Undertaking this research has therefore entailed shifting between different socially constructed domains for thought and action (Lang, Little and Cronen 1990); that is, from a 'domain of explanation' in which there are multiple equally valid perspectives and no single criteria for objective judgement, and into the 'domain of production' in which judgements about soundness and worth are evoked. Attempts to engage with these different domains 'appropriately' have led me, for instance, to eschew positivist methodologies and attempt to incorporate multiple voices in the text, but also to adhere to a fairly traditional structure for organizing and presenting the dissertation, so that the writing can be evaluated against the standards and traditions of the academic research community. This is not to say that it would not have been possible for me to have produced a less orthodox dissertation which may have been judged favourably by examiners. The increased openness to different forms of qualitative research writing is evident from scanning the recently published literature, where the influence of postmodernism has led to an increasing volume of material which presents 'data' in less orthodox and linear ways, (see for instance, Stronach 2002). Perhaps the reluctance to take risks which is characteristic of the contemporary mental health field has also led me, as a practitioner researcher, to be less experimental in my approach.

At the same time, it is important to reflect upon what has been gained and what has been lost by adhering to a more traditional format for the presentation of the research. Employing a less linear narrative form may also have served to further enhance the multi-voiced texture of the thesis, and may also have provided a more striking and therefore potentially more engaging format for readers. Stronach (2002) comments that a more playful, postmodern style of writing about action research can help to undermine the dominance of the 'audit culture' within public sector services which, he argues, has had a stifling effect on practice. While I am sympathetic towards this incitement to subvert the audit culture, it is also important to acknowledge that for me, as a novice researcher, adherence to a more traditional presentational framework felt as much like an invaluable support as it did a source of constraint. Producing a thesis has been a challenge and struggle when writing fairly conventionally, and would, I think, have felt even more daunting for me if I had also given myself an additional task of significantly departing from this tradition. Having a broad structural framework to 'write into' made the task manageable.

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In addition, one of my aspirations for the research is that it will be of interest to a wider and more diverse audience than the academic research community alone. As a practitioner researcher I hope that the study will also be considered relevant by other practitioners, and also that the stories that have been told through the research do justice to the work of my colleagues in the research site and to the service-users and families members who participated in the study. While I believe that postmodernism holds many important ideas for practitioners and researchers who wish to develop innovative and collaborative approaches, there is a great deal of postmodern literature which is extremely mystifying and impenetrable to all but the most specialist readerships (Legg & Stagaki 2002). It has, therefore, been my aspiration to discuss and apply postmodern ideas and their potential implications to practice in a manner which is fairly straightforward to read, but without removing complexity. There is a danger that an unorthodox presentation might simply alienate all but those who are already bitten by the postmodern bug. It is ironic that such exclusiveness is associated with a philosophical position which emphasizes the relationship between language and power.

Practitioner research and the production of a PhD thesis

In the process of carrying out this study I also experienced a tension between undertaking practitioner research and the production of a text that aims to satisfy the requirements for a PhD award. This tension was primarily associated with the different time-scales associated with the practice development dimension of the project and the completion of this thesis. The period during which reception meetings occurred in the research site did not extend far beyond the data-collection phase of the study: the meetings were first implemented at the beginning of 1997, and continued to occur on a fairly regular basis until late 1999. In 1999 there were several key service developments within the organization, including the development of a 24-hour crisis service. A number of the staff who had been involved in the reception meeting team moved across into the new crisis service, and so the reception meetings consequently lost momentum and subsequently occurred only infrequently. By the time I had commenced the most intensive phase of the data-analysis process, the reception meetings had therefore virtually ceased to occur. This meant that the research was no longer of direct relevance to the practitioners who had formed the reception meeting team, as the majority were occupying different roles in the organization. Since a key aim of practitioner research is that it will act as a catalyst to practice developments in the research site, this was a rather frustrating development. Although the research 'findings' were no longer of such

immediate significance in informing practice within the local setting of the research site, the study continues to hold relevance for the wider audience of mental health practitioners who may be interested in working with families and social networks in hospital settings. The increased emphasis in mental health care policy on the inclusion of families and carers, as well as the greater focus on improving the quality of hospital services (Dept. of Health 1999b) make the study particularly timely in relation to broader, national trends.

Constructing & interpreting 'data' in practitioner research

In reflecting upon the opportunities and constraints afforded by a practitioner research design for this study, it is also important to consider the ways in which my dual role impacted upon the processes of data construction that occurred. From a social constructionist perspective, knowledge is created communally, in the 'space between' people, rather than existing 'inside' the minds of individuals (Anderson 2002). Drawing upon social constructionist ideas I therefore conceived of the data generated in this study not as direct reports on an objective reality, but rather as texts which were co-produced in the interactions between myself and the research participants (Kvale 1996). The stories that participants told me as a practitioner researcher about their experiences in the reception meetings were therefore shaped by different dimensions of social difference (age, gender, class, ethnicity, culture) in the research relationship, as well as by the specific physical and social locations in which the discussions occurred.

My professional identity as a practitioner within the research site appeared to be one of the most significant factors influencing the conversations that occurred with participants, but the implications of this were of course different for individual participants, according to their own social positions within the research site (service-user, family member, professional). For instance, within the data there were several examples of professionals questioning the reliability of views expressed by service-users in the reception meetings, but no similar examples of service-users questioning the veracity of the contributions of professionals. While it is possible that service-users never entertained doubts about this, it is equally possible that they simply chose not to communicate these doubts to me because of my own relationships with the staff in the research site. Perceptions of my professional identity within the research relationship therefore appears to have been a significant factor in shaping the conversations that occurred.

It is interesting to speculate regarding the different stories that might have emerged if I had been a researcher with a service-user background. For instance, this may have allowed service-users to voice greater criticism towards professionals in the research site. Even when discussing their experiences of the research site in a manner which seemed to cast the actions of staff within the research site in a negative light, service-users and families members frequently qualified their remarks with comments that the professionals concerned were not at fault. This led me to reflect that these interviewees, aware of my relatively senior role within the research site, were careful to avoid talking in a way that might get the staff into trouble. Previous literature suggests that the researcher's identity is an important factor influencing data-collection in studies evaluating users' experiences of mental health studies. Clark et al (1999) undertook a randomised controlled trial comparing interviewer effect when mental health service-users were interviewed by service-provider interviewers and user-interviewers. These authors suggest that there was no interviewer effect found in relation to positive responses by interviewees, but that service-users interviewed by user-interviewers gave a greater number of extremely negative responses than those interviewed by service-providers.

The study by Clark et al (1999) might invite scepticism about the validity of data gathered through a practitioner research approach. If users of services feel inhibited in speaking frankly to professional researchers about their experiences, they may be even more constrained when invited to comment on a service that was directly provided by the practitioner who is undertaking the interview. It is important to remain cautious about forming positivist assumptions that because mental health service-users may express more critical views to other service-users, this is a more accurate reflection of their 'true' feelings. As Cooperrider and Srivastva (1987) have argued, research interviewing is constructive rather than simply elicitive in nature. The manner in which we talk to specific audiences is often shaped in part by what we believe they wish to hear from us, and this is as much the case in relation to the production of critical accounts as positive accounts. The meaning attributed to the identity of the researcher is also likely to be idiosyncratic, varying for different individual according to their own unique beliefs, life experiences, and so on. While many service-users might therefore feel more comfortable discussing their experiences of mental health service-users with another user with whom they may feel a greater sense of shared experience and understanding, others may prefer to talk with a professional interviewer, depending upon their beliefs about, and previous experiences of, interacting with mental health professionals.

In retrospect, however, discussions at an early stage regarding the overall aims and design of the research with different key stakeholders such as service-users and their families, and also other professional colleagues working within and outside of the research site would have been congruent with my aspiration to engage in a dialogic research process. Engaging in a consultative process of this sort may have created opportunities to co-construct the questions that were asked through the research process in such a way that the questions that were asked reflected the interests and concerns of people occupying these different social positions. A partnership approach of this sort would also have been in line with developments in the field of mental heath service-evaluation, as discussed in the previous chapter of this thesis.

The semi-structured interview format: some opportunities and constraints

In re-visiting the process of data-generation within the research it is pertinent to (re)consider the opportunities and constraints that were associated with the use of a loosely-structured interview format. In recent years qualitative researchers have paid considerable attention to power dimensions in interviews and the danger of 'researching down' rather than engaging collaboratively with participants as co-investigators, concerns that have also been foregrounded in the postmodern family therapy literature (Hoffman 1993). In this research I therefore selected a less structured, more conversational approach to interviewing as this was congruent with the dialogical practice approach which was being explored in the research, as well as being consistent with a qualitative study design in which I was interested in gaining detailed, nuanced accounts of participants experiences (Kvale 1996). Just as in the reception meetings team members attempted to avoid imposing a pre-determined agenda, the use of a loosely-structured format for the research interviews allowed for flexibility regarding the areas that were discussed. In other words, the interview conversations were potentially less 'researcher led', opening space for the participants to decide what issues they wished to discuss.

The diversity of accounts that was generated through this more open conversational interview method produced a very rich pool of data. At the same time, however, this diversity was also potentially problematic in that some themes were not explored as fully as they might have been if a more directed interviewing approach had been employed. One important instance was of this was that there was minimal discussion of significant areas of social difference such as gender, class, race and ethnicity in the interviews, and

the ways in which these differences may have shaped peoples experiences of the reception meetings, (and also their experiences of the research process). Within contemporary systemic practice increasing attention has been paid to the ways in which these discourses regarding social difference permeate our lives and relationships at every level (Dwiveldi 1999). Similarly, within mental health services there is increasing recognition of the historical complicity of psychiatry with the interests of racism (Fernando 2000) and patriarchy (Parker et al. 1995), and the need to develop more culturally sensitive and less oppressive services.

Exploration of the significance of social difference within interviews is, in most instances, likely to require that the researcher is active in opening space for these discussions and it cannot simply be assumed that because the research participants haven't directly discussed the influence of gender, for instance, that this was not significant in patterning relationships within the reception meetings. The power of discourses relating to gender, class and race in shaping our 'taken for granted' assumptions about the world and what is considered 'appropriate' and 'relevant' to speak about is in part maintained by the relative invisibility of these discourses (Parker et al 1995). A more directed interview procedure may therefore have provided greater opportunity for raising and discussing these contextual factors. A useful area for future research would therefore be to explore the ways in which participants experiences of social difference shaped dialogical and monological processes in social network meetings.

Experiences with the 'voice centred relational method' of data analysis

In the process of operationalizing Brown and Gilligan's (1992) 'voice-centred relational method' for analyzing the research data I became aware of some particular strengths and weaknesses associated with it as a procedure for use by a 'lone researcher'. Brown and Gilligan developed the method in the context of a large-scale qualitative research project which included a team of researchers involved in collecting and analysing the data. The activity of undertaking multiple readings of the data from different perspectives might flow very differently when more than one researcher is undertaking these various readings and subsequently discussing their impressions. I imagine that the presence of co-researchers might make the process of adopting different perspectives and engaging with difference easier. As a single researcher involved in carrying out and transcribing the interviews as well as the subsequent multiple readings of the interview

texts, I found that my familiarity with the material at times reached a saturation point where it was difficult to 'see' or 'hear' new things in the transcripts prior to completion of all of the readings. Similarly, as previously noted, the different readings often overlapped with one another. Despite feeling at times that the process of undertaking these multiple readings of the data was repetitive and that the distinctions between different reader positions were rather artificial, however, I also found it very helpful in generating different ideas and connections. Multiple readings allowed for an intimate acquaintance with the data, and attempting to read each time from a different angle seemed to shine a spotlight on areas that I might otherwise have missed. This process of multiple readings was also extremely helpful in providing a framework which invited me to monitor my own responses to the data, and to pay attention to those instances where there was incongruence between what the participants said any my own beliefs and feelings (Brown & Gilligan 1992). Reading the data from multiple positions was generative in relation to my own conversations with myself, with my own 'internal co-researchers'.

My organizational position(s) and the research process

For the individuals who form any system, its culture is more or less 'invisible', it can often only be 'seen' from the 'outside'. Stratton (1998, p. 155) comments,

"Everyone has things that they know strongly, unquestioningly and unreflectively. Dominant cultural assumptions tend to be of this kind. The conviction that such beliefs offer may powerfully guide and justify actions".

As a practitioner within the research site I was inevitably influenced by some of the dominant assumptions and beliefs associated with the organizational culture of the research site, as well as stories derived from the broader context of the field of psychiatry, and the field of systemic practice. In my own case these assumptions included, for instance, stories about the potential benefits and risks to families associated with engaging with psychiatry; stories about psychiatry as a means of helping people as well as an instrument for regulating and controlling lives; stories about the transformative potential of conversation, and about the value of inclusive, dialogical forms of relationship. Some of these deeply held beliefs constitute what Rorty describes as a 'final vocabulary', cherished beliefs without which I would no longer be who I am (Andrews et al. 2000). Eagleton (2003, p. 36) comments:

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"Being a person means being constituted by certain basic convictions.... What you are, in the end, is what you cannot walk away from. These beliefs do not need to be burning or eye-catching or even true; they just need to go all the way down".

The activity of practitioner research provided some important opportunities to reflexively re-visit some of these beliefs by offering different 'vantage points' from which I could position myself at particular moments to gain different perspectives on the reception meetings and the research site. As a researcher I was, in a sense, situated at times on the boundary between the 'two worlds' of the academic / research community and the world of practice. When adopting a practitioner position I was immersed in the familiar culture of the service, while a researcher position provided opportunities to temporarily 'stand outside' of this organizational culture and view it differently. This process of moving between 'practitioner' and 'researcher' positions, or shifting between contexts, was facilitated by maintaining a research diary in which I could engage in reflexive 'conversations with my self'. Keeping a diary assisted me in orientating myself in relation to which position I was standing in at particular moments. In discussing the value of maintaining a research diary as a reflective tool within the practitioner research process, Glaze (2002, p.161) comments that using a diary enabled her to be positioned, *"both within the data collection (as a researcher) and yet to remain outside of the data as self. I found I had a deeper, richer picture of the clinical areas as a result of this combination of approaches".* In relation to this study, conversations with others, particularly my academic supervisors, provided further important opportunities for reflexivity and for deconstructing my taken-for-granted assumptions regarding practice and how it should be researched.

Of the different opportunities for reflection on practice provided by undertaking the research, one of the most important was the interview conversations with the service-users, family members and professionals that participated in the research. While some of what was said in the interviews confirmed and reinforces for me ideas that I already embraced, such as that the reception meetings provided a forum where 'good quality' conversations could occur, in that many participants expressed the view that they had been listened to and taken seriously in the meetings, other views that were expressed were less easy for me as a practitioner to hear and think about. The views expressed by some relatives in the study that they would have liked to have had opportunities for confidential talks with staff outside of the presence of the service-user or other family

members, for instance, conflicted with my own beliefs about the value of bringing people together to speak more openly about concerns.

Since a key aim of practitioner research is to act as a catalyst for practice development, it is also important to consider how my own position within the organizational hierarchy of the research site may have influenced the process of implementing the reception meetings. While superficially it may seem that seniority confers influence and therefore allows for greater leverage, the complexity of power relationships within any large human system are such that a top down approach is likely to generate a degree of resistance. In relation to the reception meetings, data presented in chapter 7 suggests that they were regarded by some nursing staff in the research site as an elitist activity, a perception that may have been related in part to my status as a senior nurse and my strong association with this service development. If the meetings were perceived as being 'pushed from the top', then this would be likely to deter some staff from active and enthusiastic participation. This perception by some staff of elitism was ironic, since an aspiration of the reception meeting team was that the meetings would be inclusive and collaborative in nature. As a practitioner researcher occupying a relatively senior position in the research site I was therefore in danger of being perceived as attempting to impose a more collaborative form of practice! Since there was no intentional use on my part of my position in the hierarchy, this perception amongst some staff of elitism was unanticipated and indicated to me, as a practitioner researcher, that I had somewhat underestimated the extent to which my organizational position might influence staff perceptions of this service development.

As well as considering how my 'identity' as a senior nurse may have influenced the practitioner research process, it is also interesting to consider the ways in which my 'researcher identity' in turn reflexively influenced my role as a senior nurse. In the early days of the study, for instance, I became aware that I was at times less directive in approach than I might otherwise have been in relation to the sometimes difficult process of embedding the reception meetings into the organizational structure of the Unit. The notion of acting in a more directive manner ran counter to my initial ideas regarding what constituted an appropriate researcher stance. As my appreciation of the complexities of an 'insider' practitioner research process developed, however, I realized that there was no one 'correct' posture that I could adopt, because of the multi-levelled nature of my relationship(s) with the research site. This realization was liberating in the sense that I felt freer to move between different positions at different moments, according to the activity I was engaged in and my different responsibilities in relation to

these activities. In other words, a wider repertoire for 'responsive engagement with others' (McNamee 2003) became possible.

Summary

Lather (1991) argues that postmodern researchers should reflexively include themselves 'in' the texts they produce so that the research narrative can be read as a situated account rather than an objective report on a fixed reality. In this chapter, and elsewhere in the thesis, I have therefore attempted to make myself and my reflections regarding the research process visible to the reader as I am in agreement with Koch and Harrington's (1998) contention that positioning myself within the text in this way enhances rather than undermines the research narrative by assisting the reader to form their own judgements about the relevance of the study.

Since postmodernism as a social and philosophical movement is characterised by an 'incredulity towards meta-narratives' (Lyotard 1992), then it is important that postmodern ideas aren't uncritically accepted as an alternative form of metanarratives, a 'better' alternative to modernism (Flaskas 2002). In this chapter I have therefore explored some of the implications of drawing upon postmodern ideas in the design of the research, and the opportunities and constraints that were created through my engagement with this epistemological position. In particular, the implications for practitioner research within a mental health setting were considered. The process of attempting to undertake research which has a postmodern orientation in a psychiatric health care context where modernist assumptions prevail, and with the aim of producing a written text which meets University criteria for A PhD but which also has more immediate practice relevance has occasionally felt like attempting to meet very different agendas. As McNamee (2003) has argued, however, the role of the postmodern practitioner and researcher is to explore and bridge incommensurate discourses, rather than to revert to a polarized 'either / or' position.

Closing reflections

During the final months of writing up this research I have imagined many possible endings for the thesis: a re-visiting of the research aims; a summary of the key themes; some pointers towards possibilities for future research and practice.... Perhaps, I thought, I could end on a note of postmodern playfulness and write multiple endings, allowing readers to select the one they preferred, as in John Fowles novel, 'The French Lieutenant's Woman'? Finally, a more personal postscript, a kind of taking stock, seemed to me the most appropriate way of 'signing off', one which was in keeping with the reflexive spirit of the research and the dialogical practice I have attempted to explore and illuminate through the research process.

Undertaking this research has been a long and complex journey, one that has been part of, (and sometimes enveloped!), my life for the past seven years. Over that time there has been many changes that have touched my professional and personal worlds. Some of these changes have been wonderful: family growing and developing; meeting new friends and colleagues; exciting conversations with these colleagues and friends about research, practice and training; therapeutic encounters with service-users and families who have shared with me their stories of struggle, resilience and ingenuity in the face of extreme difficulties.

Other experiences have been more painful; the loss of two dear and much missed friends- one of these, Jim Birch, was an inspirational colleague who helped to develop the reception meetings and whose insightful, irreverent voice has fundamentally influenced my thinking in so many ways. Struggles have also been shared with colleagues in trying to develop innovative practices in over-stretched, fraught work situations where it has sometimes felt that we are all running just to avoid slipping backwards. Over this time the process of writing this thesis has been one of the 'constants' in my life, like a companion who I may not always have felt warmly towards, but who has always been with me, sometimes standing in the background but more often, right there in front of me!

The seven years that I have been occupied with this research have also seen many changes in my professional life. My connections with the research site has become gradually more distant as I have taken on different roles and responsibilities over these years, shifting increasingly into the field of education and into a different area of mental

health practice. Despite this process of moving away from the research site, I have retained a sense of connection with the Unit through the process of writing. This juxtaposition has frequently prompted me to reflect upon the relationship between practitioner research and 'actual' practice, and the possibilities and limitations of this relationship. These ideas have been discussed earlier in this chapter and elsewhere in the thesis, but there is one particular aspect of this relationship I would like to re-visit before closing the discussion. Tom Andersen, a practitioner and writer who has been a powerful influence on my own work, comments that the value of practitioner research is primarily that it enables the researcher to re-view his or her own practice assumptions (Andersen 1993b). This research has been, for me, largely concerned with exploring the idea that dialogue resides at the heart of psychiatric practice which is experienced as meaningful, and even transformative. This idea, which was such an inspiration when I first encountered it through the writings of Finnish psychologist Jaakko Seikkula (1993), has evolved, but also been confirmed and reinforced for me through this seven year research journey. The idea of dialogue remains a guiding principle in my work as a mental health practitioner, researcher and educator. Or, to phrase the matter differently, in the words of philosopher Martin Buber (2000, p. 26), *"All real living is meeting"* .

Appendix 1:

Submission to Joint Ethics Committee and confirmation of ethical approval

JOINT ETHICS COMMITTEE

Newcastle and North Tyneside Health Authority
University of Newcastle upon Tyne

Form of Application for Ethical Approval for Research Project

Notes

(i) This form must be typed or clearly printed in block capitals in black ink and, complete with associated paperwork, must be received by the Secretary to the Joint Ethics Committee at least 17 days before the meeting held on 2nd Tuesday of the month.

(ii) A 150 word summary of the research protocol must be included on page 4 of this form.

(iii) Applicants must answer all questions and ensure that the form is signed by the Project Supervisor and normally also by the responsible Clinician on page 4, otherwise consideration of the application by the Ethics Committee will be delayed.

(iv) Where applicable, the agreement to the proposed study of all medically qualified consultants and senior non-medical health professionals with responsibility for patients, whose patients may be involved, must be recorded.

I .   Title of Project:

> **Narrative study of family and staff network meetings in an adult psychiatric admissions unit.**

2.   (a)   Project Supervisor: **Dr. Maureen Gillman**

Appointment held: **Principle Lecturer**
and Institution where based   **University of Northumbria**

(b)   Consultant/General Practitioner
                     Dr. Robin Farquharson, Consultant Psychiatrist

(c)   Place where work will be carried out
                     Department of Psychiatry, North Tyneside General Hospital

(d)   Names and appointments of Associated Research Workers (including degree students where applicable):

☐ 3. A full commercial protocol, a full research protocol submitted to a financing organisation (e.g. MRC) or a complete protocol for locally arranged research is required, as appropriate. If a questionnaire is to be used as part of the research project, a copy must be included.

4. Please indicate the categories of subjects to be studied i.e. number, age, sex, and whether in-patient or out-patient:
(a) Patients: **Ten recently hospitalised patients [male & female], aged 16-65, and their families.**

(b) Patient controls: ----

(c) Healthy volunteers: ----

5. In the case of healthy volunteers:

(a) How and from where will they be sought? **The families of patients attending the network meetings will be invited to participate in the study. The invitation will initially be in writing, and subsequently by personal approach.**

(b) Will the GP be informed and if so how? **The GP's will not be routinely informed, [see question 15].**

6. What significant discomfort (including psychological), inconvenience or danger will be caused? **None. Patients and their families will be informed that they can ask for the interviews to be ended at any point if they find the discussion distressing. Similarly, the researcher, who is an experienced mental health professional, will terminate the interview if he observes signs that the patient is becoming too distressed or confused to participate.**

7. For commercially sponsored trials:-

(a) Has the appropriate clinical trial certificate or exemption been obtained? (Copy must be enclosed) ☐

(b) Has the company given, in writing, its acceptance of the A.B.P.1. "Clinical Trial Compensation Guidelines"? (Copy acceptance must be enclosed) ☐

8. Who will be responsible for the storage and dispensing of the Trial Drugs?

9. Administrative arrangements (see Notes for Guidance):-

(a) Payment to healthy volunteers: **Not applicable.**

(b) Will patients/healthy volunteers out-of-pocket expenses be met? **Not applicable.**

(c) Is the Chief Executive of the Trust aware of the proposed study and in agreement with it taking place on Trust premises? **Access and approval have been negotiated with the Service manager and Head of Clinical services for the clinical area.**

(d) Have the financial arrangements **including the potential cost of NHS Crown Indemnity** been agreed with the Chief Executive? **Not applicable.**

(e) Does any cost fall on the University? **No.**

(f) Has the project received approval through the appropriate University mechanism?
                    Yes. Approval to register for PhD gained July 1997.

(g) Details of payment from commercial sponsor to individual, department, hospital and/or university: **Not applicable.**

10. Give anticipated dates of starting and finishing study.
Start **December 1997**

Finish **2002**

11. How will the design of the study ensure scientific validity:
(a) define the qualitative methodology and/or
(b) define the statistical power e.g. 50% chance of detecting 10% variation.
(c) who have you consulted?

Please refer to the attached sheet for details of the qualitative methodology which will be employed in the study, and the names and positions of the Supervision Team.

12. Will the results be of benefit to the patients involved in the study?
Not directly. The results will benefit future patients and their families.

13. How will a suitable indication be made in the patient/subjects records to safeguard against repetitive research? **A copy of the audio / video recording consent form used in the study will be placed in the patients records.**

14. Are there any nursing implications? **The study is a nursing research project. Members of the Unit Nursing Team will be interviewed in the research.**

15. Communication with GP:-

(a) How will GP. be informed of participation in study? **The GP will not be routinely informed.**

(b) If not before, what is the reason for this? **The research does not involve any additional treatments or procedures beyond those which are now routinely offered within the Admissions Unit.**

16. Does the research involve patients not the responsibility of clinicians in Newcastle and North Tyneside? **No.**

17. What procedure is proposed for obtaining consent? (Copy of information and consent forms must be enclosed. A routine hospital consent form is not normally appropriate for research projects).
☐ **Information leaflets regarding the study**
☐ **Audio / video recording consent form**

18. What particular ethical problems do you think there are in the proposed study?

- **Hospitalised psychiatric patients may feel a sense of powerlessness in their lives, and particular care will need to be taken to ensure that patients do not feel pressurised into participating in the study.**
- **Because of my dual role as researcher and senior nurse within the research site, care will also need to be taken to ensure that nursing staff do not feel pressurised into participating.**

ALL APPLICATIONS

Summary of research protocol, including details of drugs/treatment intended (maximum length 150 words)

The study will evaluate a new development in family work for hospitalised psychiatric patients within North Tyneside. Following admission to the acute unit, a network meeting is arranged which is attended by the patient and their family; a member of the primary nursing team; any involved community staff; and members of a family therapy team from the Unit who are responsible for facilitating the discussion. Previous literature has suggested that network meetings are an effective vehicle through which the development of more collaborative relationships between staff and families occurs.

The study will examine the effectiveness of the network meetings as evidenced by the views and experiences of the participants, [family and staff]. Data will be collected using a range of qualitative methods including audio / visual recording of the meetings; individual semi-structured interviews with participants, and focus groups with the Unit staff team. Ten network meetings will be followed up in total, leading to approximately 30 interviews with family members plus 20 interviews with staff.

Signature: Project Supervisor: Date

Address for communications: **Dr Maureen Gillman, Principle Lecturer**
Division of Adult & Community Studies, University of Northumbria, Coach Lane, Newcastle

Responsible Consultant/GP: Date:

UNIVERSITY PROJECTS ONLY
UNIVERSITY OF NEWCASTLE UPON TYNE
NB: If this research incorporates invasive studies in volunteers including administration of
all information on this page is supplied, in a legible and concise form, so that the page may be copied
for the purpose of insurance cover (see information/guidance note 6).

JOINT ETHICS COMMITTEE INSURANCE REGISTRATION SHEET
Number of volunteers involved:
Age range of volunteers: to
Medical state of volunteers:
April 1996

ALEX REED: SUBMISSION TO JOINT ETHICS COMMITTEE

Title of research programme:

Narrative study of family and staff network meetings in an adult psychiatric admissions unit.

Supervision team:

Director of studies:
Dr. Maureen Anna Gillman
CQSW, Advanced Dip. Family Therapy, PhD.
Principle Lecturer, Div. of Adult & Community Care Studies, U.N.N.

Second supervisors:
Dr. David Stanley
CRCCYP, [S]CRCCYP, BPhil, PhD
Head of Division, Div. of Adult & Community Studies, U.N.N.

Dr. Chris Stevenson
RMN, BSc [Hons], PhD.
Lecturer in Psychiatric Nursing Practice, University of Newcastle.

Summary of the proposed research:

The study will evaluate a new development in family work for hospitalised patients with serious mental illness within North Tyneside. Following admission to the psychiatric in-patient unit, a network meeting is arranged which is attended by the patient and their family; a member of the primary nursing team; any community staff who are involved in the patients care, and members of a family therapy team from the Unit who are responsible for facilitating the discussion. The meetings are referred to as 'reception meetings' with aim of conveying hospitality and friendliness. Previous literature describing similar models has suggested that network meetings are an effective vehicle through which the development of more collaborative relationships between staff and families occurs [Halevy-Martini et al 1984; Seikkula et al 1995]. This in turn can enhance the assessment process and generate further treatment options.

In the initial phase of the study the views and experiences of the participants, [family and staff], regarding the meetings will be sought through individual semi-structured interviews. Ten network meetings will be followed up in total, leading to approximately 30 interviews with family members plus 20 interviews with staff. Video or audio recordings of the network meetings and research interviews will be made with the written consent of participants, for the purposes of data analysis.

A second phase of the study will entail examining the impact of this new service on the organisational culture of the unit, as evidenced by the accounts provided by members of the in-patient staff team. Further data will be collected at this stage through focus group discussions.

Aims of the study:

- To examine the perceived value and helpfulness for participants of the network meetings

- To examine the impact of the network meetings on illness beliefs of participants, [families and staff]

- To consider themes of power and authority within the meetings

- To examine the impact of the introduction of network meetings on the organisational culture of the Unit

- To generate indicators for good practice in this area of work

Research site:

An acute psychiatric admissions unit within the Department of Psychiatry in North Tyneside. The unit has 37 beds in total, [mixed sex].

Recruitment into the study:

The patient and his / her family initially receive a letter which invites them to attend the reception meeting, and also refers to the research project. All family members receive a copy of this invitation. The researcher will then approach family members personally prior to the network meeting commencing to ask if they would be willing to participate in the study, and to provide written information about the research. The meetings will be audio or video-recorded with the written consent of participants, [Family therapy meetings are currently routinely video-recorded within the service for clinical purposes, with the written consent of families]. Potential participants who do not wish to be recorded will not be included in the research. A copy of the video consent form that will be used in the study is attached.

Research Methodology:

Research site: The site for the study will be an acute psychiatric admissions unit serving a densely populated urban area. The unit has 37 beds, and offers a service to adult men and women, [aged 16-65].

Access for the research has been negotiated through discussions with the Head of Clinical Services and General Manager for the clinical area.

Research participants: The study will specifically target families in which the relative has been admitted to hospital for the first time, as previous research has highlighted the profound impact of this experience on families causal and treatment beliefs [Whittle 1996]. Contact with all participants, [staff members, service-users and their families], will initially be made in writing,

2

which will be followed by a personal approach to those who express an interest in joining the study.

Design: A qualitative research design will be used in the research. Qualitative methods are particularly useful when studying smaller populations in depth, and in attempting to develop an understanding of the multiple perspectives which are involved in a particular social setting [Rubinstein 1994; Silverman 1997]. The primary aim of the study is to consider the perceived value of the reception meetings for participants, and to consider the impact of the meetings on relationships between those who take part in them. A range of qualitative methods will therefore be used in order to gather detailed data about the micro-processes of communication which occur in the meetings and the views and experiences of participants. These methods will include semi-structured individual interviews; audio / video recording of reception meetings and interviews for purposes of transcription and analysis; and focus group discussion with staff in the latter stages of the study. Approximately ten reception meetings will be examined in total. Individual interviews will be undertaken with all participants within a week of a particular meeting occurring. Approximately 30 individual interviews with family members are therefore likely to occur in total, plus 30 interviews with staff.

First level coding of the data into coherent 'clusters' or 'chunks' will initially be undertaken, following which a more sophisticated process of second level or pattern-coding will take place in which themes are identified in and across the transcripts [Miles & Huberman 1994].

Researcher bias: Since the site for this research is also my agency base, where I am employed as a senior member of the nursing team, ideas and methods from the field of practitioner research [Reed & Proctor 1995] will be utilised in order to clarify and facilitate the negotiation of social roles between myself and the research participants. I will, for instance, keep diary / field notes throughout the course of the research, which will provide a secondary data source in relation to my evolving relationships with staff and families participating in the study [Burgess 1985].

Ethical issues: All potential research participants, [service-users, family members and staff] will be informed in writing their participation is entirely voluntary, and that a decision not to become involved in the study will not effect the clinical service that the service-user and their family receives. Written consent will be sought for the audio-video recording of meetings and interviews, and assurances provided regarding issues of storage and confidentiality. In order to preserve confidentiality, names of participants will be altered at the writing up stage.

References:

Burgess, R. G. [1985] *In the field: an introduction to field research.* Allen & Unwin: Harts. UK

Halevy-Martini, J., Hemley-Van Der Velden, E., Ruhf, L. & Schoenfeld, P. [1984] Process and strategy in network therapy. *Family Process.* Vol. 23: 521-533.

Reed, J. & Proctor, S. [1995] *Practitioner research in health care.* Chapman & Hall: London

Rubinstein, R. L. [1994] Proposal writing. In Gubrium, J. F. & Sankar, A. [Eds.] *Qualitative methods in ageing research.* Sage: California USA.

Seikkula J., Aaltonen J., Alakare, B., Haarakangas, K., Keranen, J. & Oberg, T [1995] Treating psychosis by means of open dialogue, in Friedman, S [ed.] *The reflecting team in action: Collaborative practice in family therapy.* New York: Guilford.

Silverman, D. [1997] *Qualitative research: Theory, method & practice.* Sage: London.

Whittle, P. [1996] Causal beliefs and acute psychiatric hospital admission. *British Journal of Medical Psychology* **69:** 355-370.

JOINT ETHICS COMMITTEE

Newcastle & North Tyneside Health Authority
University of Newcastle upon Tyne
University of Northumbria at Newcastle

at the Centre for Health Services Research
21 Claremont Place
Newcastle upon Tyne
NE2 4AA

Our Ref: WMR/LK/jc
Your Ref: RGF/WP/pers.ReedA

26 February 1998

Dr R G Farquharson
Consultant Psychiatrist
Sir G B Hunter Hospital
The Green
Wallsend
NE28 7PD

Dear Dr Farquharson

**Evaluation of Family and Staff Network Meetings in an Adult Psychiatric Admissions
Unit**
(Min Ref: 98/18)

Thank you for your letter of 19 February addressing the concerns expressed by the Joint Ethics Committee when it considered your application in respect of this study.

In the light of the information and revised documentation provided I can now confirm the grant of ethical approval in respect of your research study application.

Yours sincerely

Mr W M Ross
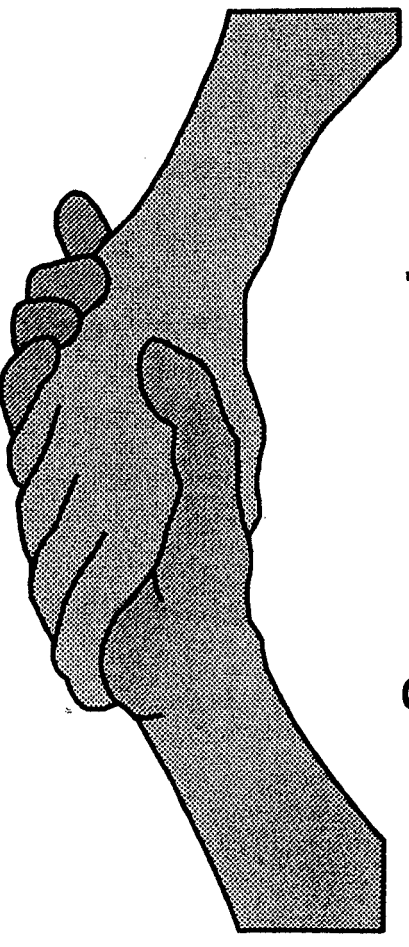**Chairman**
Joint Ethics Committee

FARQUHA2.DOC

Tel (0191) 222.5274
Fax (0191) 222.6043

Appendix 2:

Information about the research for participants

Ward 21

Reception Meetings

Information Leaflet

- **What is a reception meeting?**

Entering hospital may be a stressful or worrying experience, both for the person coming in, and also possibly for any relatives or friends who are close to them. For this reason, we believe that it can be very useful to arrange an informal meeting in which you and your family or close friends can talk with members of the staff team about your recent experiences; any worries you may have or information you might need about our service; and also any ideas or suggestions about what might be most helpful to you at this point in time.

- **Who will be invited to the meeting?**

As well as you and your family or close friends, a member of the nursing team from the ward will also attend. If there are any other professionals who have been working with you before you came into hospital, it may also be helpful to invite them, so that they too can share their thoughts and ideas.

The meeting will be organised and hosted by members of a family team which is linked to the Ward.

- **When will the reception meeting take place?**

We believe that these meetings are most helpful when they occur within a short time after entering hospital. A member of your primary nursing team will arrange an appointment time for you. **The reception meeting will only take place if you wish it to do so.**

The meetings take place here in the hospital.

- **Research Project**

A research project is currently being undertaken into the reception meetings, in order to help us find out what aspects of the meetings people find most useful. The results of the research will help us to improve the service that we offer. The researcher may be contacting you before this meeting, to ask if you would be willing to participate in the research. You are under no obligation to do so if you do not feel comfortable with this.

- **Further Information**

If you would like to meet with someone to discuss arranging your reception meeting, please approach your primary nurse, or ask to speak with Alex Reed or Val Tippins.

> ## Research project: reception meetings in an
> ## acute psychiatric admissions unit
>
>
> *Alex Reed*

Dear

I an writing to let you know about a research project that I am carrying out which is supervised by Dr. Maureen Gillman from the University of Northumbria. The purpose of the research is to find out more about what happens when people come along to reception meetings on the Ward. In order to learn more about this I hope to talk with members of staff, service-users and families about their experiences and views regarding the meetings. The results of the research will be used to help shape the way that reception meetings are organized and how this aspect of the service will develop in the future, as well as to inform my own practice.

The research project will be ongoing over a number of years, and I will be gathering data by carrying out interviews as well as through informal discussions and meetings, so it is therefore very important that as a member of staff on the Ward you are aware that it is taking place. If you have any questions, comments or concerns about the project, I would be very happy to discuss these with you in confidence. The research is at a very early stage at present, but I will circulate information periodically in order to inform the Team about how it is developing, and again, I would be very pleased to receive your responses and suggestions.

One of the things that I intend to do in order to gather information about the reception meetings is interview members of the staff team, and I may approach you at some point in order to ask whether you would be willing to share your views and experiences with me in this way. I am very keen to find out the views of staff in detail so that the planning and delivery of the reception meetings can be informed by your ideas. Any discussions that occur will be confidential, but it is important for you to know that you are not under any obligation to agree to being interviewed for the study, and you can decline to participate in this way if you do not feel comfortable with the idea.

Thank you for your kind assistance,

With regards

Alex Reed

| Research project: reception meetings in an |
| acute psychiatric admissions unit |
| |
| Alex Reed |

Dear

I am currently undertaking a research project looking at the Reception Meetings which occur on the Ward, and I would be grateful if you would consider assisting me with this. In the first phase of the research, I am hoping to meet with members of the Ward Team on a one-to-one basis, in order to find out about people's ideas regarding the meetings, [in the second phase I hope to interview service-users and relatives in order to learn more about their views of the meetings]. The results of the research will be used to help shape the way that reception meetings are organized and how this aspect of the service will develop in the future, as well as to inform my own practice.

I would therefore like to meet with you for approximately 20 minutes, to talk about any experiences you might have of reception meetings so far, and also any ideas and suggestions about how this service might develop in the future. I would also like to make an audio-recording of our meeting so that I can review it at a later date, if you are comfortable with this. Any discussions that occur will be confidential, but it is important for you to know that you are not under any obligation to agree to being interviewed for the study, and you can decline to participate in this way if you do not feel comfortable with the idea.

If you would like any further information about the research project, I would be delighted to discuss this with you in more detail.

Thank you for your kind assistance,

With regards,

Alex Reed

> **Research project: reception meetings in an acute psychiatric admissions unit**
>
>
> **Alex Reed**

Dear

Research project: Ward 21 Reception Meetings

I would like to invite you to take part in a research project that I am carrying out which is supervised by Dr. Maureen Gillman from the University of Northumbria. The purpose of the research is to find out more about what happens when people come along to reception meetings at Ward X, and I would be very grateful if you would be willing to assist me by sharing your views and experiences about this. The results of the research will be used to help inform the practice of staff working in this field.

I understand that there may be many demands upon your time, so it may be helpful if I outline exactly what this participation would involve:

I will need to interview people who attend the reception meeting, in order to ask about their experience of the discussion. This interview is likely to last approximately an hour, and could take place either immediately after the reception meeting or at another time that is more convenient for you.

I will also need your permission to make an audio or video recording of our interview conversation, so that I can review the discussions at a later date. The highest standards of confidentiality will be maintained- tapes will be stored securely and erased when the research is completed. If you do not wish to be recorded, you are free to decline. You are also free to decline to take part in the research.This will not in any way affect the service you receive and the reception meeting will take place as planned.

If you have any questions about the research, feel free to contact me on the above number and I will be happy to discuss these. If you wish to discuss the project with your General Practitioner before deciding whether to take part, it may be useful to show your Doctor a copy of this letter and the information leaflet about reception meetings.

Thank you for your kind assistance,

Yours sincerely

Alex Reed

CITY HEALTH

NHS Trust

MENTAL HEALTH PROGRAMME

Suite 21/22, Albion House
Sidney Street
North Shields
Tyne and Wear
NE29 0DW

Tel: (0191) 219 5909
Fax: (0191) 219 5902

**Research Project: Reception
Meetings in an Acute Psychiatric
Admissions Unit [Alex Reed]**

Dear

Thank you for agreeing to be interviewed as part of the above research project. It would be very helpful to me if our interview is audio-recorded, as this allows me to review the discussion at a later date.

The tape will not be used for any other purpose other than the research study, and the highest standards of confidentiality will be maintained. The tape will be erased when the research is complete. You are also free to ask for the tape to be erased at an earlier dated, and your wish in this matter would be respected.

I have discussed the above, and I agree to the interview being recorded:

Name(s): ....

Date: ....

Thank you for your kind assistance.

Yours sincerely

Alex Reed

Appendix 3:

Additional information regarding the research participants and data

a) A full interview transcript which includes the annotations made during the process of data analysis to illustrate the reflective process.

b) Extracts from the research diary.

c) Extracts from observational notes made during the process of practitioner observation.

d) Two case studies based on individual research participants, a service-user and a professional, which weave in various sources of data.

Additional information regarding the research participants and data

a) A full interview transcript which includes the annotations made during the process of data analysis to illustrate the reflective process.

Please note that names have been erased in the text to preserve anonymity

Interview with M████ 22-7-98 [daughter] of C████████: interview occurred on Ward ██

A: Before you came to the meeting, did you have any information about what the meeting was going to be about?

M: I didn't know what to expect.

A: So, none of the nurses... or you hadn't seen anything written down or anything like that? There is leaflets around, but you hadn't seen anything like that?

M: No. Well, it was just, more or less, said that it was just for a chat, kind of thing. It wasn't anything formal or anything like that.

Does 'just a chat' minimise the significance of the meeting?

A: Oh right, so you were told that it was just a relaxed sort of chat? What did you feel about going then? Were you nervous about going, or did you feel OK about it?

M: No, I was just glad to get in there so that maybe my Mam might... to see how my Mam was more than anything else. I wasn't thinking about anything... how I would feel, it was more like, how my Mam was going to take it and stuff. But, I thought she did brilliant.

Putting concern for mother before concern for self

A: Right, Okay- because that came out in the meeting, didn't it? People said that she talked.... you were really impressed with that?

M: Yeah, I thought she would have been.... It took a while for her to say anything, but I think that once she realized that there wasn't going to be questions hammered at her she felt a little bit more at ease.

A: Were you worried when you were going to the meeting that questions would be hammered at her, and she might be put on the spot?

M: I tend not to think about anything when I'm going into anything, I just keep an open mind- if I don't like it I'll get up and walk out. But you've got to try it, haven't you?

Identifies self as open minded - approaching new situations with an open mind

A: If you hadn't liked the way it was going, would you have said something?

M: Yes. Maybe not in front of, where my Mam was. I would have said, "Well look, I'm just going to pop outside" or something, and let it carry on because, just because I'm not happy about it doesn't mean it's rubbish or anything.

A: Right. Was there any point when you were tempted to do that?

M: No.

A: What was your overall impression or feeling about the meeting?

M: It was mixed, I think.

A: Right.

M: It was good, and it wasn't. But it wasn't, like, bad. I can't really explain it.

A: Maybe I could ask you about both bits then? What was good about it?

M: Because everyone else just sat and talked about other situations and that, didn't they? And what they felt that they were getting off it. But like you weren't, you didn't have to say anything back, and it wasn't like put to her in any way. It was like, "Well we're talking, and if you want to join in, join in". But, then, there wasn't any direct questions to her, as well, which I was expecting.

A: Was there some direct questions that you were hoping would be asked that weren't?

M: I don't really know, because everything was like mixed anyway. I was hoping that everyone would ask her questions, but nothing too personal, at that point anyway. But just like to see if she would open up, even a little bit.

A: You said at the beginning that it was good that she wasn't getting questions thrown at her,

Would have dealt with differently by leaving

shift from 'I' to 'you' (more neutral)

recurring idea of ... with everyone ...

This idea of focusing on the identified patient, eugene asking her questions' ... is contrary to my systemic belief about aiming to help the index patient become less central within the system

but when you said that, I'm wondering if you wished that...

M: I'm like contradicting it ! [laughs]

A: Well, we all do that- I'm just wondering if you wished that we had pushed a bit harder in some ways?

M: No.

A: So it was good in that way, the conversation was pretty free for people, and your Mam was joining in that. But there was some ways in which the meeting was less good, or less useful, for you?

M: It was like that many things was going on in my head anyway, and with the last two months or something of being there with my Mam, it was like, I had loads and loads of things still going on in my head, so it was like... to sit and listen all the time, I was like looking out of the window at some points, because I was like totally full of everything really.

A: You were overloaded then, were you?

M: Yeah. But then when- was it Brian that was sitting there- and the other woman, when those two started speaking it was a lot easier. When those two were- like you were able to pick up on things- because there's questions that you want to ask, but then you're forgetting all the time. I had loads of things that I wanted to ask but at the same time when it came to it I was, they were gone, you know? But as soon as those two started talking about what they felt about what was happening, it was easier to pick up on that.

A: Oh right. So that helped you?

M: It's good. In the first place when they were going to do it, I was thinking... but it was good, the way that they done it.

A: Yes, because it is a bit of a strange thing isn't it? But you did find it helpful?

Identifies herself as full up, relocated

shift from 'I' to 'you'

overloaded

IMPORTANT QUOTE RE ...

M: Yeah, and they picked, I think, up on what was happening and that, and how my Mam felt, I think. Yes.

staff understand Caroline's feelings ←

A: I think that what you're describing is probably quite common for relatives, they come and their minds are full of stuff- the situation has probably been going on for some time back at home before the person comes into hospital- is there anything else that would have helped you with that?

M: I can't think at the moment- I'm totally overloaded me! [Laughs]

overloaded +++

A: It's a stressful situation- that's why we decided to have the meetings in the first place, to try and recognize that....

juggling commitments

M: I think at the moment, I'm more thinking about what's going to happen now- like, I go to work at 6- 00pm in the morning, and my Mam's going to have so many hours on her own. It's that now, it's not what has happened, it's like that now that's on my mind [laughs]!

A: One of the things that we've been wondering about is that the meetings are 'one off' meetings at the moment- supposing that we'd said, "lets all meet again next week"?

My question doesn't seem to follow on from Maria's last comment - I'm interested in keeping the interview 'ontrack', while Maria is interested in discussing her mothers current care plan.

M: More of them, yes.

A: You would have been pleased about that?

M: Yeah. I think if that had even happened every day, or even every other day, straight away in a full week, or even if it was just for half an hour every day, I think that my Mam would have opened up even more.

A: It would be really nice to do it that way, I think- to have meetings every day, or at least to offer it every day like that, but it could be, for a visitor, quite stressful in another way, coming every day for meetings- but do you think it would have been supportive for you?

M: I think it would have been more, yeah. Better.

A: Some of the things that you're raising about what happens next...

M: I haven't been, no disrespect to anybody, but I haven't been told anything- I don't know what's happening, I don't know if anybody's going to come and see my Mam. It's like, literally, to me now, it feels like- "you look as though you can cope now, off you go". I'm frightened in case she does get back into feeling the same.

A: Should I see, before you go- I'll see Margaret [nurse] who's on tonight, and see if I can get information about what the plan is?

M: Yes.

A: Your Mam doesn't know either, then, does she?

M: Two weeks. We've been told just to come back in two weeks.

A: Right- okay, we'll just check and see. When we're finished talking, I'll check and see what information's available in the office.

M: It's like just being, just today, like, "There you go", sort of thing, and I know that just before my Mam came in, she was at her worst then, and I know how I felt then- I think I wanted to come in to the next bed with her [laughs]! So if it want back to that...

A: Okay. We'll see if we can find out what the plan is.

M: I've already been on the phone for one of her friends to come round in the morning. But without letting my Mam know that. So that when I go to work, I know that in the morning Margaret will at some point at least phone her, or pop along.

Handwritten margin notes:

Check of relationship with staff

uncertainties about what happens next

I shift from researcher position to practitioner position

I'm frightened

This feels uncomfortable for me - Maria's approach to planning Caroline's care may infantilize Caroline?

A: So you've been very thoughtful about that. Did you have any conversation with your brother about the meeting after you left?

M: He thought it was good. He was also, he made more on the point- like when my Mam said that she had loads of friends and she sees them- well, she has got a lot of friends, but she was always at work and she was always making sure that she never went anywhere anyway. Not even to come and see us, really. Kevin was trying to say, "Well yes, you have got friends, but don't hide and say "oh yes I do see them", when she doesn't see them.

A: He was worried that she might give us a false picture?

M: It's hard to understand my Mam, because for like sixteen years she's had certain things hammered into her, so I don't think she's been 100% honest, so I don't know if now when I say, "how do you feel, are you OK?", and she says, "Yeah". You [the staff in the meeting] picked up on that as well, not saying what you actually mean. Just saying what everyone else wants to here.

A: Yes, Asante said that at the end, didn't he? He said, "You don't have to agree". What did you think about that?

M: I agree. He picked up on it, and I thought that was good.

A: Was there anything from your point of view that you were hoping would be said that wasn't said?

M: No, because I didn't really go into it with...

A: Yes, I'm thinking as I asked you that, you've already told me that. What I wanted to ask you instead is, were you sitting with... I think one of the things that I'm concerned about is that when people come to meetings sometimes they can feel a bit overwhelmed- especially when there's loads of staff present.

initial impression of staff

M: That was daunting at first.

A: Was it, yes? Then some people might respond to that by having things that they want to say, but not being able to find the words to say them, or feeling too inhibited to say them. Was that the case for you? Was there things that you wanted to say but it was difficult to do so?

M: Yeah, and they were just going out of my head, and when someone was asking a question, then what I had wanted to ask was just, like, gone. I had like forgotten! It was weird, really. Because I was listening to everything, and then I was picking up, and I was like... Then when it was time to talk, it was forgotten, because I had been like I say, there was that much going on inside of my head anyway.

overloaded, crowded thoughts

A: Did you feel that the meeting was long enough? It was about an hour, wasn't it?

M: I could have carried on.

A: Do you think it would have been better if we'd carried on then?

M: Just carried on. It' like when you put a time limit on anything anyway, its...

A: I think an hours usually about the time that we have for the meetings, but do you think that if it had run it's course naturally, it might have gone on for longer?

M: Yes. Probably have got more out of it, from us.

A: Have you any suggestions about if we were to change anything about it? Because there's others in the same kind of situation, and we have meetings like this regularly, is there anything that would improve it?

M: More of the sitting back and listening to the... I don't know, nurses- what do you call yourselves?

A: Yeah, there are different staff at different meetings at different times. I think that all of the staff who were at that meeting were nurses though.

M: Well if the nurses were more talking about.. like hoying things back at each other...

A: You know that you said that when Brian explained it, you thought, "Oh, what's this?" Any suggestions about how it could be explained? Because there is a difficult bit there, isn't there, about trying to explain something which is quite unusual.

M: No, it didn't threaten me in any way.

A: But then you seem to be a confident person.

M: If I don't like it then I'll just... I've watched it, I've watched this happening to, well just say it's not my Mum but somebody else. I've sat and watched it happening, so like I suppose anyone who tells me what to do, I just look [inaudible]. But I'm not saying, at the same time, that I wouldn't go away and think about it, and if I thought it was right, I'd say, "Well, fair enough". But like when things are just hammered at you, I just.... I'd rather sit and think about it first.

A: It sounds as if what you needed, from what I'm hearing, is an opportunity to be able to think about these things and talk about them, but an opportunity to sit back a bit as well..

M: Sit back, yes.

A: And when Brian and Glynnis were talking, that gave you a chance both to listen and to sit back a bit as well?

M: I dunno, I thought for some reason when everybody was talking, I thought that my Mum should have been joining in a little more, but that's like pushing someone isn't it? But for some reason I thought my Mam might... even if it was just, "Oh hello, how do you do? I've been doing this today", or whatever.

A: Do you think that it would have been helpful if we'd invited her in a bit more, by asking, "What do you think about this?" and those kind of questions?

M: Yeah. Yes.

A: Because I've got the impression that this was quite a concern for you, about how much your Mum talks and participates in this way?

M: Yeah. But I think my Mam was, like, before we came in, when we were outside, she was like, the first thing she said to the nurse was, "I don't have to answer any questions?". So I think my Mam was thinking that she was just going to be bombarded with a lot of questions and she was shocked, and at the end of it she said, "That was all right".

A: So she was quite frightened as well that she might get hammered with questions?

M: Yes, she was terrified of what questions were going to be asked of her.

A: Do you think that, I don't know the full story with your Mam because I haven't been directly involved in working with her, but I picked up in the meeting that she's been in a difficult relationship, and that was around in the discussion, but it was never talked about very directly, and...

M: Yes, I was like slipping things in, and I was trying to slip things in, but it still didn't want to come out.

A: Would you have preferred it if one of us from the staff side had said, "Lets talk about this", or do you think that it would have been...

M: I think it would have been too much for my Mam.

A: So you think it was better to touch on it but not really go into it?

I find myself uncomfortable with the degree to which Mana wished the staff to take a more facilitative (parental?) role.

M: Yes. It was, I think my brother was the same, we were saying the odd thing, to say to my Mam, "Well look, we're saying it and nothings happening". You know, you can say what you think and nobody's going to start getting up and ranting and raving, and threatening you or whatever. You can say what you want to say. She did though, she did speak, but to me it was the same thing, it was like yes and no, but on the terms of what she thought everyone else wanted to hear, rather than- still- what she was wanting. But it was still... she was surprised as well.

A: Yes, the meeting kind of ended then- Asante said that and then the meeting kind of ended [I think that here I am not following what M is saying]. Is that something that you would have liked to have gone on talking about, or did you think it was good to end there, as kind of something to think about?

M: Well, it left us to think about it, didn't it?

A: Sometimes I think it's quite good when things end at a point where.. it gives something to mull over. Have you talked with your Mum about the meeting since it ended?

M: Yes, she thought it was good. She enjoyed it- as much as you could [laughs]!

A: Yeah.

M: She didn't expect it to be that, she honestly thought that you were going to come in and just bombard her with questions, and like, it wasn't, so...

A: So anything would be a relief! [Laughs]

M: Yes.

A: You know when you spoke about your Mum not talking so much, has that been the same between all of you, in a sense?

M: Well she's told me a lot, but still... I now know a lot more, a lot of things she kept to herself. And because she kept those things to

herself, I've been worried that with her being in
here, she still wouldn't open up. But I think that
she has to one of them. I think she's told them
bits, but only... but even then, I think it's only as
much as what my Mum feels she needs to say,
not what she wants to say. But enough, what she
feels she needs to say. There is another point
which, now I'm thinking, with these meetings, is
maybe not two people who are close to the
family- because me and my brother want the
same thing, but we've got different views a bit,
and I think that we could probably end up
arguing. Because what one says, the other one
might agree with a little bit, but not totally, and
then you'd be... I was dying to say, "Well, hold
on...", and some of the things that I had said, I
could see that he wasn't happy about. So I think
that maybe, not to many of the immediate
family- just one of the immediate family, but at
different times. Well say its a person with three
kids, one time one of them go in, the next time
another, the next time the next one. Because I
think also, you tell people different things
anyway, don't you?

A: Yes, so there's the potential to hear different
perspectives, different angles.

M: I'm thinking that now, because after that and
other things that's happened, I've got annoyed
because my brother's said things and I've been
at the situation all the time, but at the same
time, he's still got full right to say and think how
he feels, as well. You know, so I've been like
"No, no", and walking away, but at the same
time its maybe- done separately.

A: Did it leave any tension in the air between
you then?

M: Mmhh.

A: A little?

M: Yeah, yeah. I mean at the end of the day we
both want the same thing, but everybody's
different, everybody's opinions, everybody's way
of doing things is different, so it was crossing on
peoples toes, really.

A: I was wondering, sometimes in these situations men and women see things differently, as well?

M: well I've been listening to my Mum for the last sixteen year, and my brother hasn't, and it's hard to explain to him certain things, because like he doesn't know, like the other person involved. He knows who he is, he knows what he does, he knows that, but he's never any actually sat down and had any conversation with him, so it's like hard to day to him, "Well yes, he is a sod, but at the same time I can also see why my Mam was like fond of him really", because nobody can be evil- you know their nice and then they're evil, but then they're sorry, and they're nice. So it was hard to say to Kevin that you can't just expect somebody to get up and walk away, whereas my brother works away and [inaudible].

A: You've got a more complex understanding of the situation, in a way, because you've..

M: I've been more involved in it, yeah. He's manipulated me, so I've been understanding how my Mum's been feeling, and it must have been shit really. They could have been heartbreaking to you, but you've still spent years with them- you remember the good bits. And it was hard to, hard to... I mean, I still don't understand why, don't get me wrong. I'll never ever understand why somebody, no matter whether they're male or female, how someone can stay with someone and get so much abuse. I'll never ever understand it, but you've got to try and come to terms with it, haven't you?

A: People have their reasons, however complicated they might be.

M: And it was hard to say that to my brother, and I think that when we were in that meeting, some of the things that he was saying, I was getting like, "Oh"! And I could see that sometimes when I was saying things, I could see that hew wasn't happy.

*How might the conversation have been different if I was < woman researcher

exploring just how long she has been in this supportive prison

gender

complexity of feelings towards X, only some of which could be expressed in family court

alludes to her own relationship with Kevin

struggling to comprehend

A: Now that you say that, it makes m think about what we were talking about before, that if there was more than one meeting, it would be... if you come for just one meeting and these things get raised it can be a little bit tense, if there had of been a meeting the next day...

M: The next day would have been a lot more relaxed..

A: You could have maybe brought that out, it would have been a chance to get it a little more out in the open?

M: We would have killed each other [laughs]! No, it wouldn't have been like that.

A: No, I don't think so. I didn't get that impression at all, I was struck by how flexible everyone was, actually. When you were coming to the meeting, did you... I know that you said before that you didn't give it a lot of thought in advance, but I'm just wondering if you had any worries that it might end up in a disagreement or a row?

M: No, that never crossed my mind.

A: Because sometimes when it comes to bringing family's together, people do worry about is it going to be like a powder keg or something like that.

M: No, I didn't worry about that, I didn't worry about it.

A: It's been very helpful getting your views so far, but is there any questions that I haven't asked you that you were expecting to be asked?

M: Like I say, I never thought about what I was going to be asked. I don't like to, because when something is asked, it's not something that you've already gone over. I just keep an open mind.

A: Well there's a lot to be said for being spontaneous.

M: [laughs] I do tend to go away and then remember things, and think, "oh, I didn't really agree with that, why didn't I say that?" And then the next day I forget about it anyway!

— wish to continue talking

A: After the meeting on Monday, was there anything where you went away afterwards and then thought....

M: Well, I was still wondering what the coloured fellow was doing there, because he didn't really say much.

← Anonymity of staff

A: One thing I'm hearing from what you're saying is that you maybe weren't clear about who we are? Because you asked before about, "Are you nurses, or..?" Maybe we didn't explain that clearly enough?

M: You work in the community?

A: Well Asante works for the Community Mental Health Team, he's a Community Psychiatric Nurse. The reason we have someone from the community team is so that when your Mam is discharged from the Ward, the community team have got some information more than just a letter from the Ward, so they've got a bit of a better understanding.

I didn't answer Maria's question about my own role.

↑ my position here?

M: You see, while we were talking, I was watching everyone else. I was thinking, "they're trying to suss me out!". I was wondering if you were trying to see our reactions or anything, which obviously you probably were, but it was, I dunno.

A: yes, well I think we're trying to move away from that a bit, you know. From thinking of the sessions as a kind of therapy where we're analysing people.

M: Yes [laughs].

M: I think that we're trying to let that go, and just be more of a kind of.. to meet with people and have a conversation and.... [tape ends]. [Other side]... would of been kind of watching

me, and watching what I was saying and watching what I was doing.

A: Was that an uncomfortable feeling?

M: Well, it didn't stop me.

A: Yes, I'm pleased about that, but...

M: As soon as I was finished speaking I was looking at them, and that... I was thinking... [long pause]

A: Apart from the numbers of staff, was there anything else that people did that made you feel you were being analyzed?

M: I was worried in case I said the wrong thing- for whatever reason, I don't know.

A: Did you ever say something and then think, "Oh, I'm saying the wrong thing here"? Was there ever a point when you felt that?

M: No, no. Apart from when I said, "My Mam thinks she's in here for life. I thought, "OOPS, I probably shouldn't have said that", because I think that she did think that. I was just saying it, like in banter, but after I did say it, it was like.... my brother sort of looked at me.. [pause]. Mind you, if my brother hadn't of looked at me, I probably wouldn't have thought anything of it. But he gave me a funny look, and I sort of looked and thought, "Maybe I shouldn't have said that".

A: I thought that it was a really important thing to say myself, because it's such a common worry that people are coming here. Do you think that that worry got talked about enough?

M: Well even the next day she still wasn't convinced. She still didn't believe that if she wanted to walk out she could.

A: So maybe there wasn't enough said to reassure her about that?

M: No, because I think it took a couple of days really, and then she asked, "Can I go for a walk?", and when they said "Yes", it was only then that she actually believed... There was shock on her face, "I can?". I said, "Well that's what we've been saying". She couldn't take it in.

A: Going back to what you said before about the number of people present, was there too many people there for you, in a sense?

M: No.

A: It felt okay? I think we do try to give some thought to that. Sometimes the family come, and there's only two or three of them, and there's three or four professionals there.

M: I think that it would be too much if there was two or three family there and then that. I do.

A: There was only three of you though, wasn't there?

M: Well like, say if there was.. her brother's about the same age as me, and Paul's been like a son to my Mum, so I suppose even like if he came in on it. I think it would still be... I think there should only be one at a time.

Mona reiterates her belief that family members shouldn't be brought together

A: Right.

M: It's like, how many brother's or sister's have you got? Have you got any?

A: Yes, I've got a sister.

M: So there's only the two of you, there isn't anyone else. So you could say anything to your sister couldn't you?

Relationship with me & beliefs about family life

A: Well it's an interesting question- we're not that close, actually. If we were in a similar situation, we would have different opinions.

M: Different opinions.

A: Yes, so that's a good point you're making.

M: So, if she was going to one house, and you were going there, she could be talking about something totally different from what you talk about. Sometimes it gets crossed over and you get different views of it. Then when you come together, it's a bit awkward. It's like now, am I supposed to be cruel to be kind, or do I pamper my Mam, or do I watch her? Do you know what I mean? Am I supposed to watch her twenty four hours a day, do you know what I mean? Or should my Mam like.. even cooking, should I say, "It's OK, I'll do it if you don't want to do it", or say, which I've tried to say before, "You just cook for yourself and don't worry about me", should I go back to doing that? I haven't got a clue. I know that's got nothing to do with the meeting today.

A: No, but I'd like to try and respond in some way. A couple of thins about what you're saying come to mind for me- one is that if there's an arrangement for your Mam to meet with someone from the Community Mental health Team, I'm sure that you'd be welcome to join in the discussion have some contact, because you're raising some very practical things that people have to work out. But as a rule of thumb, I think that- I can say this then I'd be interested in what you think about it- I think that if families get too much into treating the person like they're ill, if they get too much into treating them like they're sick, when things are really difficult maybe it can be helpful, but if it goes on too long I think it can hold the person back. I think that you'd be better off to assume that your Mam's capable and that she's going to do things.
for herself.

M: Right, yes. To me, she is, so if she does do those things then that's great, because it's a normal part of life, isn't it?

A: Yes, obviously if you find that she's...

M: I mean if she's sitting there really sick and cheesed off... you see, like, tomorrow I'll go in and she's had her tea, or she's made me something, I'll say, "Oh, well I'll do it tomorrow

if you want?", then if she does carry on doing that, then that'll be great, I'll think "She does do the normal things, there's no need to push her". But the, if you've got to continuously say "Come on, iron your shirt" and so on, well she can't be properly well. I mean, if she carries on doing this, and then stops, well you're going to get down days, I'd say, "Oh, don't worry- it's nothing, I'll do it", but if carried on all those down days...

A: Yes, well I think there's two things there- there's the initial thing when you're Mam comes out of hospital, well I don't know a lot about your history, but that's quite a new arrangement isn't it? It will take a bit of getting used to for both of you.

M: I've lived on my own for twelve years! [Laughs]

A: Well that'll take a bit of getting used to for both of you, I would have thought. But if longer term you have some concerns about how active your Mum is and thing like that, then...

M: If she's happy, then that's fair enough. Even if she's not going out and things, but as long as she's happy and looks OK.

A: I wonder if this might be a good place to end the discussion, and then I can check in the notes, or ask Margaret [primary nurse] about what's happening, then that might give you a clearer idea. [I go on to explain about the CMHT intake system, etc.].

Additional information regarding the research participants and data

b) Extracts from the research diary.

Please note that names have been erased in the text to preserve anonymity

Additional information regarding the research participants and data

c) Extracts from observational notes made during the process of practitioner observation.

Please note that names have been altered in the text, and some details removed, to preserve anonymity

2/6/97

Issue of 'persuading' Ward primary nursing staff to arrange Reception Meetings - there are currently several blank appointment spaces, despite a large number of new admissions

- Memos sent to F. grades, & write in 'communications book'

I have also tended to leave notes for primary nurses, asking them to arrange meetings, with little success. For instance, left one for ~~Sophie~~ re new client ~~_____~~ - no action taken.

Possible ways forward:

- Reception meetings not yet part of the culture - Clients (and staff?) feel they are being singled out?

- Staff feel they are only appropriate when relationship issues are prevalent?

- To staff learn negotiation skills necessary?

I am aware of a shift in my own thinking, from 'why are the staff so inefficient', to curiosity about how to introduce a new development into a system. How do I research this?

Research agenda also creates a pressure - what if meetings never 'take off'? What if reception team get discouraged?

27/6/97

Reception meeting for young woman who was admitted with ? drug-induced problems. Also attended by Mother, Father, & primary nurse (████) ████ Meeting hosted by V██ and I, got off to a late start because of a double booking. Client very weepy at beginning of meeting, and I said we could take discussion at her pace. As meeting continued, client

behaviour became more, rather than less excited, strange, 'psychotic'. She is on Sec 2, and pleaded with parents to let her go home, while giving a contrary communication about the 'appropriateness' of this through her actions.

- During the meeting I was very conscious of ~~Julie's~~ presence, as she
  - hadn't been to a R.M. before
  - strikes me as one of the more 'sceptical' nurses, who previously worked on a secure unit for a few years. She is unlikely to have been persuaded about the value of R.M's from this experience.

- After meeting, V~~ictoria~~ and I 're-viewed' meeting, and wondered:
  - Would it have been 'better' to say at the outset that any participant can ask for meeting to ~~stop for~~ break off if feeling too distressed.
  - Parents had very strong expectation

that medical staff would be present at the meeting, which would provide an opportunity for discussion of diagnosis. Were these expectations constructed through discussions with ████ ?

30/6/97

Several meetings cancelled following mix-up over how to arrange them - North Shields team asked ████████ to arrange a series of R.M.'s - ████ was unaware of the procedure and booked several meetings into the file, but without informing client, relatives, etc, so nobody knew about the appointments!

This seems to raise interesting issues in terms of introducing a new system into the organization -

Did this 'error' occur because:

• Nurse didn't feel comfortable in handling negotiations with client/family (training issue)?

• Style made communication difficult (organizational issue)?

• A reluctance to accept responsibility prevailed (█████ had spoken with V██ (Wkd Clrk), who apparently queried whether families knew about the meeting dates, and J█████ replied c/b not my job, its the primary nurses' and she's on holiday! (cultural issue)?

I have decided to intervene as if it were an organizational/communications problem, and ~~k███~~ will circulate a new, simplified guide to arranging the meetings.

18·7·97 Ongoing problems about new clients being admitted but no RM arranged. Question is how to introduce more sceptical or inexperienced staff to idea that systemic meetings might be useful? Perhaps with M████ returning to

the Ward, there will be another
'R.M. ambassador'?
Consultation Meeting on Thursday 28th
August to discuss medical input to
Ward. This might have crucial impact
on Reception Meetings, (and also
discharge arrangements).

20/8/97
    Spoke with F████████ to invite her to
join the RM team, which she is keen
to do. Mentioned concern about issues of
hierarchy and speaking her mind — said
that she had heard it said within the
Unit that RMs are as staff orientated
as other types of meetings, and would wish to
challenge this if she found it to be so.

28/8/97
    Strategy meeting to discuss the future
organization of in-patient services, and
particularly, changes to medical input,
(2 consultants, rather than 7). I remember
feeling that we'd ~~one~~ 'won the day'
with this one, and also reflecting on the
dangers of this way of thinking. The

Reception meetings were mentioned several times over the course of the morning (and these connoted as 'a good thing'). The meetings were seen as an important part of admission procedures, and maintaining good links during transition from hospital and community.

In some ways, it is ironic that the staff referred to the RMs favourably in this way, as they are currently happening only very occasionally on the unit.

Notes from Meeting of Reception
Meeting Team, Tuesday 21st October '97

The meeting was held at the North
Tyneside Carers Centre, and the following
people were present; F̶r̶a̶n̶c̶e̶s̶, ̶J̶a̶n̶,
K̶a̶r̶e̶n̶, J̶e̶n̶n̶y̶, B̶a̶r̶r̶y̶, V̶i̶c̶, C̶h̶r̶i̶s̶ (for
● 1st part), M̶i̶k̶e̶, G̶i̶l̶l̶i̶a̶n̶.

The first part of the meeting was a
review (notes made at the time) –
Issues included <u>timing</u> – meeting will
occur a while after admission –
however, even then, families still seem
keen to tell the story of events
preceding admission – seems important
● for this story to be told. Identified
lot of ways service-users & families
have used meetings, as an alternative
to 'what is the purpose of the meeting'
F̶r̶a̶n̶c̶e̶s̶ ('Its about finding a common language
... the client has a new language and
not the family).

There was also some sharing of concerns about the 'one off' nature of the meetings — does it build up expectation unfairly? Is this more our desire for further involvement, rather than the families' ███ asked, 'Could it be a one-off meeting with the possibility of convening another on request?'

The concern about the 'danger of exclusiveness' was expressed — 'Are we an exclusive group? What do other in-patient staff think about the meetings?'. One member of staff was cited as describing the meetings in terms of being an invitation, more work... ███████ received the comment 'You're one of the elite now'. It was agreed that staff should be invited to sit in on the meetings.

The issue of note-keeping was discussed, with the team broadly preferring a record keeping sheet will

minimal discussion of themes, dynamics,
etc. ▓▓▓▓ felt it is useful for
Ward staff to have more detail —
▓▓▓ raised the "ideological" issue of
an "authorized" version of the meeting!

In writing these notes a few days
after the meeting, a few issues are
raised for me in relation to conflicts
(potential) in relation to the various
hats I wear — responsibility as an
"organizer" of the team, (notes etc.),
senior nurse on Ward, member of
RM team, researcher These conflicts
feel most apparent in relation to
my role in the Ward.

Notes from Supervision Meeting
with David & Maureen, 28·10·97

Talked about issues raised and dilemmas around roles of practitioner/researcher. It occurred to me that in order to create change in a psychiatric hospital environment, passion and persistence are necessary, otherwise stasis is likely to prevail — ~~this~~ a very involved position. Research (from a traditional perspective) may require a more detached, observer perspective.

Discussion in supervision about how notion of data collection needs to be wide, a sort of ethnographic approach. Also discussed my dilemma about taking time during working week, especially when not actively interviewing, completing forms (ie thinking not proper work"). Led to a discussion about this more reflective activity in relation to research activity. Connection here

(isomorphic pattern) between my responses to this and those of the Ward staff who express the view that attending meetings is not 'proper work' (which is observations, medication, etc

4·11·97

Talking with ██████ (█████) in my office at TW/1 about Reception Meetings — ██ mentioned that one of the staff nurses (█████) had made a remark in London about how ████ ~ young (17) client had not found the Reception Meeting that recently occurred useful. (Similarly, he had mentioned the other day that ████ mother had commented that she didn't find it helpful).

I found my responses to this very complex —

'Who gave her a job here anyway?!!'

Starting to darkenise some of the

including dept. Plans are in place for referral to 'supported' accomodation. Things seem to be moving very fast towards a mental illness career — Staff felt things should 'slowdown' (Myself, ████, ████ (primary nurse), Mother may have felt criticised by this questioning. At end of meeting,

- Mother gave ████ a completed application for hostel, and said, 'This isn't easy for me, you know.'

- There was no period of reflecting team discussion in meeting, as 1████ arrived very late. Might this have led to a more dialogical ethos for the meeting?

- Was staff scepticism the issue, rather than critical feelings of family? The feedback was 'not heard' direct from the source', but via staff.

11.11.97

Reception meeting today for A▮▮▮ a 40ish man with a drink problem. Attended by I.P., W▮▮▮▮▮▮▮▮, K▮▮▮▮, myself & (▮▮▮ P. (Primary Nurse). Afterwards, ▮▮▮▮ raised questions about whether she should attend, what contribution duty worker ca make regarding follow-up, particularly in the case of alcohol or drug problems. My anxieties were raised by this, as I see W▮▮▮ as an important ally, and the willingness of the N▮▮▮▮▮▮▮▮▮ team to send a duty worker as important steps, hopefully with other teams following suit in years to come.

There was no reflective process style discussion in this meeting — perhaps because both K▮▮▮ and W▮▮▮▮ arrived late, or because there was 4 professionals present and only one service-user. I was reminded, however, of how the reflective process may have been useful not so much in commenting on service-users, but on relationship between

service-user and staff (for instance, in this case, relationship of /dependency that seemed to be forming), and on the professional prejudices of the interviewer. In this meeting, I asked the service-user about his frequent references to self-harm, including an account of how he had been admitted following talk of killing himself. I enquired about

• whether these were 'tactics' (not in this language) to influence relationships. This now seems to me to be a potentially unhelpful professional prejudice, not linked with theory the clients' account — possibly also risks inviting client to increase their pattern of action. Reflective conversation may have commented on these discussions.

<u>18.12.97</u>

• Informal conversation with (░░░░░) and (M░░░░░░) on the Ward, who were asking about the difficulties in arranging reception meetings.
  M░░ asked if the staff understand the purpose of them, and contrasted the lack of R.M.'s being arranged with the

previous ~~meeting~~ ~~should~~ 'Intake meeting'
system, (in which a meeting was
arranged the same or next day following
addmission, to review:

· If admission is needed
· Care planning issues

These meetings were attended by a
ward nurse, intake worker, client and
other significant others. M~~~~ suggested that
the rationale for the meetings may have
been clearer to staff than will
reception meeting

I said that there is a more
general problem with implementation of
developments on the ward, and compared
the situation between community
and hospital teams :- In community
teams a new idea will either be
accepted or received critically, but if
accepted it will be implemented and
this is usually quite straightforward
with hospital team, my experience has

been that new ideas are often received enthusiastically, but practice does not alter to accomodate/implement them. ▆▆▆ said that this may be because community staff feel more ownership of clinical developments, and therefore are more empowered. Hospital team may feel more "done to". I replied that my plan to improve the arrangements around R.M.s by passing the responsibility from nursing to admin staff may therefore not succeed? ▆▆▆ commented that "if empowerment/powerlessness is an issue for ward staff, they should have right to veto new developments (which of course left me thinking about the future of the research!).

Notes from Reception Meeting for R S on this date. R admitted 24-1-97 2nd admission], Section 2, Consultant D.

Present at meeting: Mr. & Mrs. S [H's Parents]; S [Educational Worker]; Interpreter; G R [Primary Nurse]; G, S; C & myself reception meeting team.

Issues raised:

- R chose not to attend
- Clarification regarding names [R & Parent's surnames]
- Issue of families request for woman doctor, and R not to be examined by a male
- Request for transfer to women's area
- Friday is day of religious observance for Muslims
- Agreed to meet again next week, with R again invited to attend.

Issues raised in discussion following meeting:

- Team learning from family and interpreter about cultural issues
- S writing notes during session, [this not negotiated]- also passing notes to G, disagreeing with comments from family

2nd Reception Meeting for R S.

Present: Parents [Mother did not attend initially]; S; D [Ward representative in place of G R]; Interpreter; C, G & myself. R again declined invitation to attend.

Issues raised:

- S wished to share thoughts prior family arriving and asked not to
- Mother and R not present initially, father went to get them and returned with Mother
- Long discussion within meeting about R being 'angry' or 'frustrated'. This was connected by S with issue of cultural tensions: wish to wear western clothes etc vs. Being a 'good Asian girl'. Parents said that this is not an issue. The conversation continued to focus on this topic despite signs of discomfort shown by Parents- talk becoming increasingly monological in nature
- Mr. and Mrs. S asked about examination of R and medication, worried that R might have a brain disease. This was again handled by me in a monological manner, by explaining that H was not physically. G touched on the issue of the trip to Bangladesh not happening-
- Agreed to arrange a further meeting, in the Women's Area lounge, in the hope that R will attend if the meeting goes to her
- Long discussion with Interpreter after the meeting, who advised the team about cultural issues.

3Rd Reception Meeting

J T : 1st Admission, Sec.2, Consultant: B

Present: T; D[husband]; P S [primary nurse- arrived late due to handover &
incident on the Ward Team- myself & V [Reception meeting team]

Issues

- Meeting is three weeks after admission- T & D emphasized that it would have
  been much more useful on admission, which was particularly difficult. T was
  sectioned because she was felt to be suicidal. Both D and T felt that this hadn't
  been discussed with them, they were informed of the situation by the GP in the
  presence of their 14 year old son- D said, "It was like being shot". T feared she
  would never get out- the 3 day Section was converted to a 28 day Section.
- T felt "betrayed" by the CPN who persuaded her to come to the Ward
  informally
- Couple have made a complaint. They were left waiting for a long period in the
  Ward area on arrival, not approached by staff. PS was the first person who they
  feel entered into conversation with them, after three days
- Discussed discharge, effect on family relationships- D's extra vigilance,
  incident where he had said to T, "Are you OK, do you want to go back to
  hospital?"
- D and T spoke about how they have come to mistrust professionals because of
  the admission experience- including at the Reception Meeting. T said that she
  only wants minimal follow-up from services on discharge.

After the meeting V, PS and I met. The reception meeting was felt to have been
helpful, but that it would have been most helpful if it had occurred at, or shortly
after, admission.

D and T's account of professional 'deceit' was almost shocking to listen to. PS
mentioned concerns about T's possible suicidal thoughts, which he did not raise

in the meeting- issue of 'secret' professional talks about 'sensitive' issues- how do we address this?

Additional information regarding the research participants and data

d) Two case studies based on individual research participants, a service-user and a professional, which weave in various sources of data.

   Please note that names have been altered to preserve anonymity

Brief case studies of two research participants, a service-user and a professional, and their respective experiences of the reception meetings they attended are provided below. The purpose of these case studies is to add further contextual detail for the reader, by providing examples of the kinds of life-situations, dilemmas and difficulties that the research participants might typically have faced. The case studies are developed, and particular issues highlighted, by weaving into the discussion data which were generated from various sources.

Names, and some minor 'factual' details have been altered to protect the anonymity of the actual participants.

Case study 1: Christine

Christine was a white woman in her early twenties who ran a printing and design business, which she had established together with her husband, David. Christine and David had been married for two years, and they had a baby son. The couple were living in a rented flat, and felt dissatisfied with the standard of the accommodation and the area they were living in. Money had been tight for them since starting the business. Christine's parents, Stanley and Jean, lived nearby, and helped out a lot with child care. Christine was spending more and more time at her parents home, and David had concerns that their marriage was drifting apart. Christine described some ambivalence about becoming a mother. She loved her son, but felt that the family had very traditional expectations of her, including a view that she should either stop working or reduce the hours she put into the business to spend more time at home. For Christine, developing the business was an important creative outlet, and she had dreams of becoming very successful with this.

Tensions were building between Christine and David not only about whether or not she should work, but also about David's view that they should spend more time together as a couple in the evenings. Stanley and Jean tended to take David's side in these disputes, provoking even greater feelings of frustration and rage for Christine. She felt at times like a prisoner, trapped by her family's expectations of her, and also felt that nobody was listening to her point of view. The more angry she became, the more her husband and father would tend to view her behaviour as 'irrational' and therefore invalid. She described herself as having to shout louder and louder to try and make herself heard. In the semi-structured interview that was undertaken with Christine, she described this process as follows:

Christine: I have a problem with my Dad and my Husband, getting the message across. The pair of them seem very pally-pally, and it's really difficult getting the message across, saying, "Listen to this little woman here, I exist!" It's very difficult getting that message across. So I feel that I'm in a bit of a circle at the moment. If I want to say something, I have to lose my temper a bit, and that causes even more problems.

Alex: So you've got to shout it rather than say it?

Christine: I've got to shout it rather than say it, because I feel that they don't listen- and then they complain that I shout, and say, "Yes we do listen!", you know? It's just really hard, you know?

As the emotional temperature increased, Christine's family became concerned that her 'unreasonable' behaviour might represent the early signs of some form of mental illness. Stanley and Jean were aware that the arrival of a baby and the transition to motherhood could be traumatic. After Christine was born Jean had herself been diagnosed as experiencing psychiatric illness, and had been hospitalised for several months. In the research interview Christine went on to discuss these concerns that her father held:

Christine: Yes, my Dad wanted to get me into hospital, because my Mum, she suffered from really serious post-natal depression, and I think my Dad was thinking, "Deja vu- Christine's got exactly the same as what she had". And that's been some bad experiences that my Dad's had. He had to look after me single-handedly when I was a baby, and my Mum was in hospital for a long period of time. She's got rare blood, or something. My Dad , I think, was thinking that I was going through the same sort of problems as my Mum's got, but I haven't, you know? I think I'm more like my Dad than my Mum.

Alex: But that was his anxiety?

Christine: That was his anxiety- he was thinking, "Oh my God, she's going through exactly what my Wife's been through, and I've got to get her into hospital, and I've got to get her fixed". That's what he was saying! [Laughs] So he's fixed, and she's better, you know!

Stanley was afraid that history was repeating itself, and had therefore encouraged her to seek help. Christine did eventually go to see her GP, who made a referral to the local community mental health team. A psychiatrist and CPN from the team assessed Christine, and recommended family therapy, with the intention of 'de-medicalizing' the situation and helping the family resolve the tensions between them.

The situation came to a head one night when Christine became very excited and distressed, and walked out into the streets near her home in her bare feet saying that she was seeking somewhere to sleep. She also described hearing a voice speaking to her from inside her head. Christine was admitted to the Unit under the Mental Health Act (1983) for further assessment. The following extract from observational notes I made following a reception meeting provides a brief account of the circumstances surrounding Christine's admission to hospital, and an indication of the degree of concern that her actions were generating for those around her:

From the discussion in the meeting I gathered that Christine had been admitted to hospital in a very excited state, and Dave [primary nurse] used the expression "thought disordered". She had also, I believe, said that she was hearing voices. She had previously been in contact with the CMHT, and her Father had worked hard to get her admitted to hospital, bringing her to the doctor or A & E Department five times in the couple of weeks prior to admission.

The initial contact between the family and the community psychiatric team had clearly not been successful in resolving the problems without recourse to hospital treatment. Christine's father, Stanley had continued to feel very worried about his daughter and felt strongly that she needed to be in hospital. Stanley was puzzled by the team's emphasis on relationship factors when he believed his daughter to be ill. Christine referred to her Father's confusion about this in this extract from her research interview:

Christine: He's saying, "Why are the doctors not wearing white coats now?". He expects it to be all the same as it was when my Mum was in hospital. He says, "I can't tell the difference between the doctors and the patients now!" "I can't tell the difference between the nurses and the patients!".

Shortly after Christine entered hospital a reception meeting was arranged on the ward. The following extracts made from observational notes immediately following the reception meeting provide a flavour of the discussion that occurred in the meeting:

(As well as Christine), The meeting was also attended by her husband, father, Dave [primary nurse], Karen [student nurse from CMHT], Carl [CPN], myself & John [Psychiatrist]. The discussion in the meeting seemed particularly rich- the professionals involved didn't linger to share impressions afterwards, but Dave commented to me in the corridor that it was "a good reception meeting", and John made a similar comment in passing....

In the meeting, Christine said that when she had come into hospital she was "blaming everyone else for her problems", particularly Father and Husband. She said that she could now see that she was to blame, and that she had been childish and self-centred. She added with a twist that her Father and Husband were very controlling, but they had given her so much that if they wanted to control her, that was OK. She described her Mother, who was at home looking after Christine's child as very passive and controlled. Much of the discussion centred around where Christine would live on discharge, and she said she had decided to return to her Parents home for a while until she and her husband could find a better house.

In the meeting Christine seemed to be oscillating between blaming herself for the difficulties she was experiencing and blaming the men in her family. In a research interview with John, her psychiatrist, he expressed concern that Christine might have been "capitulating" to the family's view of her as 'ill' within the meeting:

John: Yes, the thing that sticks out most clearly is .... well I'll use the form of words that first comes to mind, the sense of myself, but I heard Christine buying into the family account for the first time. The family account of "she's defective, and she needs fixing in some way". Because certainly at previous meetings- it's impossible not to refer back to previous meetings- at previous meetings- at previous meetings there's been this really quite lively interchange between Christine and Father in particular about whether there's something wrong, and what is there that's wrong, and Christine has argued her corner in more and more extreme terms..., ...so there arguments begin to spill over into unconventional ways of arguing, and there was no sense of, I didn't have that sense of her arguments spilling over into forbidden territory in the reception meeting. Rather, this very strong contrast of her fitting in and doing a lot of agreeing.

Within the meeting people remained very polarized in their views, however, and the talk was characterized by a series of conflicting monologues, rather than dialogue. Mechanistic

metaphors seemed to abound in the discussion, with talk of Christine's behaviour becoming more "controlled", and even of her needing to be "fixed". Christine, in the research interview, described her Father's beliefs about her as follows, *"he probably would say, "Oh, I've been to the hospital, and she seems to be getting fixed", that kind of thing! I think that's what he'd probably say! I feel like I'm a car, that I'm being fixed!* Christine continued to oscillate between the view that the problems were connected with gender issues in the family on the one hand, or that the situation was her fault as she had been "selfish". Her husband David, while expressing the view that Christine was 'ill' and needing hospital treatment, also agreed with Christine that there were tensions in their relationship which needed to be discussed.

Staff in the meeting were careful not to further exacerbate this process this by confirming a medicalized account of the situation. Instead, they proposed the idea that there was a middle view between the position that the difficulties were all of Christine's making, or that they were all the families fault. The staff also attempted to lend credence within the meeting to Christine's view that gender issues within the family needed to be discussed by attending to this aspect of the discussion. At the close of the reception meeting important differences in perspective between the different participants remained, but it seemed that the possibility of continuing to explore these had been kept open rather than closed off. A 'middle ground' position was agreed whereby Christine remained in hospital, but a further family therapy meeting was also organized to focus upon relationship tensions and conflicting ideas about the future. Karen, a student nurse who attended the reception meeting commented in a research interview, that, *"everyone seemed to have a lot to say, so that one went well"*. Christine herself described this 'middle ground position that the family achieved as follows, *"I was glad, because I made... I reconciled with my Dad, I gave him a big hug afterwards, you know?...And I knew that my husband and me need to sort a lot of problems out as well, and I knew that we came to the right decision. It helped a lot, you know?"*.

Case study 2: Jane

Jane was a white social worker in her early thirties who had worked for a number of years in a day centre for people with long-term mental health problems. She had been in contact with Marion, one of the people who attended the centre, for some time, mainly providing practical support, and periodically becoming more intensively involved when crises occurred for Marion or her partner Jim, who also experienced mental health problems. As a social worker, Jane was a warm, helpful and supportive in manner and generally well liked by colleagues.

One Monday morning, Jane received a telephone call from a member of the Ward team asking if she would be available to attend a reception meeting later that day. This was Jane's first day back at work after being on holiday, and she learned that Marion had been admitted to the Unit at the weekend, following the sudden death of her Father. The reception meeting took place on the Monday afternoon, and was attended by Marion and Jim, June, Sue and Pete (nursing support workers on the Unit), and myself. This was the first reception meeting that Jane had been to, and in a research interview she said that she had been unclear about what to expect from the discussion:

Jane: (I was told) only that it might be too short notice, but they were holding a meeting, and (pauses), just that Marion had been admitted on the Saturday, and it was a lot to do with the death of her father, and that was it. No information about the reception meeting. I think that I assumed it was going to be the same as a Care Programme Approach meeting, and.... (pauses) but she didn't say anything about the meeting itself.

In the absence of prior information about the reception meetings, Jane drew on her previous experiences of other meetings within the service such as CPA meetings to orientate herself. Because of the contrast between the goal-orientated and relatively-structured style of 'typical' CPA meetings and the unstructured style of the reception meeting, Jane went on to express her surprise regarding the direction that the conversation did take. In particular, the extent to which the reception meeting was primarily focused upon Marion's feelings of grief about her Fathers death came as a surprise. Jane herself was more preoccupied with what she described as *"practicalities"* surrounding the admission, and was concerned that the absence of a

doctor at the meeting meant that medical treatment had not been discussed to the extent that she had anticipated. This left Jane feeling rather frustrated:

Jane: Yes, I think that I did view it as an information giving and receiving session, that was from my point of view, and I felt that afterwards, from my point of view, I hadn't got the information that I needed. We hadn't gone through what had led up to the admission, and Marion had mentioned that Dr. Price (consultant psychiatrist) had changed one of her tablets prior to admission and she'd been hallucinating. I don't know if she was still on that tablet, that's why I think she was asking about the medication, and Jim (Marion's partner) was quite concerned about that. I think the pair of them had fixed... the way that Marion had gone was due to this tablet that she'd been given two days earlier, and I don't think that had been cleared up for her, for them, you know? That seemed to be one of the issues that they had both come out with. And there was no Medic there either, there was no notes there to say what she was on. So, that was something we had to go after the meeting and sort out a bit.

June's perception that the reception meeting was over-focused upon Marion's emotions did not, however, appear to have been shared by Marion herself, who in a research interview commented that she had valued the opportunity to speak of her grief:

Marion: I experienced it as, that they (the team) talked to me. You know, I was... I can't say it straight... I felt right there.

Alex: Did you, yes? You showed a lot of tears, and you were upset in the meeting...

Marion: I lost my Dad, you see. It gave me a chance to talk with someone and tell them how I felt.

One of the reason's why Jane experienced frustration with the meeting was her scepticism about the 'true' value of the discussion that had occurred, as she felt that Marion was a rather histrionic person who liked to 'play to an audience':

Jane: I think she (Marion) actually... I mean, I know that she was very distressed, but I think she actually likes meetings, she likes appointments, she... I know that it might sound an awful thing to say, but she sometimes plays up to these meetings. I often accompany Marion to out-patient appointments and she presents completely differently from sitting in the waiting room with me to going in and talking to the consultant

psychiatrist, it's like... she's got to be looking and presenting as very, very ill, and crying a lot. And I think that people in the room obviously didn't know her, you weren't aware of that, you know, and also, some of the things that she was saying, there was a little bit of a slant on them, and... I thought that it's not really the right time for me to step in and say, "Well actually, this sometimes happens", and I felt that there was a lot of background to it that yourself and some of the nurses perhaps weren't aware of, and I didn't feel it was the right arena for me to step in and contradict Marion in front of new people to her... and also, whether or not you had a right to know, as well, you know? I think she was serious in what she told you, I didn't think that she was telling you the whole picture.

For Jane, there was a sense that Marion was performing a familiar routine in the meeting, but that the other staff who were present would not appreciate this because they didn't have access to the "whole picture" regarding how she tended to conduct herself before professional audiences. Jane's orientation towards a modernist, medical explanation for Marion's recent crisis invited her to privilege talk about drug treatment and 'practicalities' over emotionally focused conversation. Similarly, viewing Marion's behaviour through this modernist lens also invited her think of Marion's behaviour as being less than 100% genuine. The idea that there is one 'true' picture of a person that can be achieved through skilful assessment or through familiarity is commonplace in psychiatry, and runs counter to a postmodern emphasis on multiplicity. This issue was highlighted for me as a practitioner researcher, during the process of data-analysis, as the following extract from my research diary illustrates:

While transcribing the interview with Jane there is an issue which is brought into focus for me which seems to be a familiar one: Jane had previous knowledge of Marion, and from this previous relationship has an idea of her as someone who is perhaps prone to dramatizing issues a little or enjoys having an audience- this idea introduces a slightly sceptical note for Jane regarding the value of what is being discussed, and a sense that if the other professionals present knew Marion's history a little more, they might view the conversation differently. This reminds me of situations for instance within the CMHT where a member of the team might assess a client, then report back to the team. The person who carried out the assessment might have been impressed by the potential for change in the situation, and report back positively to the team. However, members of the team might have had contact with the person from the past, or have received other information which leads them to be more sceptical. This is usually seen as introducing the reality of the situation and dispelling an over-optimistic account [the

person doing the assessment was somehow "taken in"]. Privileging this previous story about the client may have the effect, however, of closing off the opportunity for the development of a new story.

Returning to Jane's experiences of the reception meeting that she attended, despite her reservations, she did identify the meeting as having been beneficial in some respects for Marion:

Jane: She (Marion) was certainly calmer after the meeting, she was able to, she'd opened up, from being sort of, from not looking at any one and not talking, not wanting to speak. You know at the start of that meeting she didn't want to speak, when the meeting finished she looked me in the eye, which she hadn't done and she started telling me things that she wanted to happen for her. Maybe that meeting had enabled her to do that afterwards?

Although the absence of a medical focus within the reception meeting was rather puzzling for Jane, she was also able to identify an important qualitative change that seemed to occur for Marion as a result of the discussion. Jane felt that the reception meeting appeared to have been 'enabling' for Marion, helping her to find her voice. The distribution of power in the relationship between Jane and Marion also appears t have altered in that Marion, who previously appeared to be without voice, began to look Jane in the eyes rather than averting her gaze, and expressed her wishes regarding what should happen.

Appendix 4:

Relevant publications

Reed, A. (1999) Psychiatric hospital admission and interpersonal 'closure': Network meetings as a means of countering closure. *Human Systems* 10(1): 35-48.

Reed, A. (1998) Systemic approaches to mental health care in Finland. *Thinking Families: The Newsletter for Family Therapy & General Practice.* 13: 2-4.

Reed, A., Stevenson, C. & Wilson, M. (1998) Social network meetings ease trauma of psychiatric admission. *Nursing Times.* 94(42): 52-53.

Psychiatric Hospital Admission and Interpersonal 'Closure': Network meetings as a means of countering closure

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ABSTRACT

The dominant socio-cultural discourses regarding psychiatric disorder within western societies invite us to view mental health problems as located 'within' the individual, and people who are defined in this way as lacking in insight, personal agency and responsibility (Scott, 1973). Ascribing a diagnosis of mental illness to a person may therefore result in their problems becoming viewed as unrelated to their social context. One consequence of this is that when a crisis situation is defined as psychiatric in nature a form of interpersonal 'closing off' may occur between the person in difficulty and their family or significant system. This process of closure is frequently exacerbated when hospital admission occurs (Scott & Ashworth, 1967; Whittle, 1996). Scott (1973) has used the term 'treatment barrier' to describe the obstacles to providing a therapeutic response that are created by this state of affairs.

In this paper the concept of interpersonal closure is examined in relation to psychiatric hospitalization. The use of family/staff network meetings following admission is discussed as a forum for addressing these problems of closure and the treatment barrier.

Introduction

The term 'closure' has been used by psychiatrist and family therapist R.D. Scott (Scott & Ashworth, 1967) to describe the process in which a person in crisis may become emotionally disconnected or closed off from his or her significant others and wider social context. Closure is associated with the person's problems becoming defined as a consequence of an illness process which is located 'within' the individual, so that the problems are seen as disconnected from the interpersonal, cultural, and political contexts of their life.

Scott (1973) has suggested that the process of closure begins before any professionals are called onto the scene, as one member of the family or social group in crisis has begun to be regarded by the others as 'ill' or 'mad'. The professional entering this situation is often expected by those involved to confirm a view that is already becoming established that the person is ill. According to Scott, the arrival of psychiatric professionals into a crisis situation can exacerbate a process of closure by signaling confirmation that the person is ill, particularly if the outcome of this professional intervention is admission to a psychiatric hospital. If the difficulties which the person is faced with are confirmed by the professional to be features of an illness over which the individual and their significant others have no influence or control, responsibility for managing the situation tends to be handed across to the professional system at this point. The manner in which the professionals intervene during this crucial stage of flux will therefore play a major

part in shaping how the problem is subsequently viewed or defined (Dallos, Neale & Strouthos, 1997; Haley, 1980; Reed, 1998).[1]

I will now outline some of the key societal, professional and familial discourses about mental illness which may become operational when a person enters a situation of extreme crisis and receives a psychiatric diagnosis. Relationships that are formed between mental health service-users and professionals will be permeated with meanings derived from these discourses, and so this is a key area to consider for practitioners who are aspiring to work therapeutically in this context.[2]

Societal discourses about psychiatric disorder

Scott argues that the dominant cultural beliefs within western society about mental illness include the following (Scott, 1973; Scott & Starr, 1981):

- that psychiatric disorder occurs as a consequence of biochemical or genetic factors
- that the problems are located 'inside' of the individual
- that the person who is afflicted lacks 'insight' into his or her true situation
- that the person lacks responsibility or personal agency

The belief that people experiencing mental health difficulties pose a risk to the public has also become prevalent in recent times, as a consequence of some notable tragedies which have further fueled public anxieties about the failure of community care as a project. Media coverage has tended to both reflect and provoke these anxieties by portraying people with mental health problems as unpredictable, irresponsible and often dangerous (Johnstone, 1994).[3] In response, recent policy initiatives within the UK have tended to strengthen the coercive aspects of psychiatry's social function.

The consequences for a person in crisis of receiving a diagnosis of mental illness can therefore be extreme. When an individual is defined as mentally ill in this way, 'illness' may come to define their identity as a social being. Gergen (cited in Gergen, Hoffman & Anderson, 1996) has described this state of affairs as the "tyranny of diagnosis", a

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[1] The role of mental health professionals in the development of constraining illness narratives has, of course, been a commonly discussed theme within the field of family therapy, but it was Scott's contribution to apply this concept within the field of psychiatric crisis intervention (Whittle, 1996).

[2] The term 'discourse' is used in this article in the sense described by Parker (1999), referring to historically contingent patterns of meaning which organize the different symbolic systems that people inhabit, and which are crucial for us to make sense of each other. As such, discourse shapes and limits the ways in which it is possible for us to act and think. For instance, a discourse about 'family' might describe relationships as 'naturally' revolving around a nuclear family structure, and as if all other patterns of living and relating must be measured against it.

[3] For instance, the government's recent White Paper on mental health (Department of Health, 1998) declares that community care has failed and places a central focus on the role of psychiatric services in managing risk and protecting public safety. This emphasis on risk can be regarded as a political response to public anxieties which have been inflamed by garish media coverage concerning people with psychiatric problems — a recent analysis of Home Office statistics found that the number of homicides by people with a psychiatric disorder have only shown very slight fluctuations between the years 1957–1995. While the overall number of homicides within the UK has increased, the percentage committed by people with psychiatric problems has shown a slight annual decline (Taylor & Gunn, 1999).

situation in which every move the person makes in their life is dysfunctionalized. Commenting on this process, Ron Coleman, a leading figure in the UK user movement, says:

> *"Yours are called hobbies, mine are seen as 'obsessions'. If you don't clean your house for a week, you're a lazy sod. If I don't clean my house for a week, I lack daily living skills! A symptom of schizophrenia, I'm not a lazy bastard, I'm ill! That's the way it works. That's the nature of power".* (Coleman, 1999, p. 66)

The person who is regarded as mentally ill may, for instance, come to be described as a 'schizophrenic' or a 'manic-depressive' in such a way that no space exists between the individual and the illness that has been ascribed to them. The traumatic events associated with the crisis therefore come to define the person's identity, rather than being life experiences that he or she can relate to. As the Australian family therapist Michael White has noted, this process of internalizing the dominant societal discourses about mental illness has profound implications for the person's life and relationships, as these internalized discourses:

> *'...have the effect of isolating persons from each other, and from the very contexts of their own lives. These discourses have provided for a way of speaking and thinking about life that erases context, that splits experience from the politics of local relationship'.* (White, 1993, p. 20)

The term 'closure' describes this rift or distancing process through which a person in crisis becomes disconnected from the network of intimate family and social relationships in which they ordinarily live their lives, and which provides the context for the difficulties that have occurred (Scott & Ashworth, 1967). Psychiatric practice which fails to take account of the individuals social context may inadvertently exacerbate this rift, and in the following section I will discuss some consequences of the dominance of medical discourses within the mental health field.

Professional discourses

It is perhaps stating the obvious to say that medical discourses regarding psychiatric disorder predominate within the professional world. The medical approach permeates every aspect of contemporary psychiatric practice, shaping the pattern of services and the type of care and treatment people receive (Johnstone, 1994). Discussing the treatment of schizophrenia, Birch (1991) examines the instruction that psychiatrists receive into this disorder through the professional journals. Birch carried out a brief review of articles on schizophrenia in two leading British journals published between 1985–1986 [the British Journal of Psychiatry and Psychological Medicine]. From a total of forty-one papers focusing on schizophrenia during this period, only one reported on practices which might be directly useful in conducting an interview with is intended to be therapeutic with a person identified as schizophrenic and/or their significant others. All of the other papers addressed either issues of pharmacology or discrete pathology

from a medical perspective. Birch (ibid., p. 23) goes on to argue that psychiatrists reading papers on schizophrenia in the academic journals are implicitly instructed that:

- schizophrenia is a complex topic only understood by brain scientists
- research into discrete pathology will eventually yield a cure
- the clinical role of the psychiatrist is centred on intelligent prescribing
- people troubled by schizophrenias are "schizophrenics" whose speech can be abstracted into utterances which in turn can be reduced to diagnostic markers

Social context comes to be regarded as, at best, of secondary importance, as for instance, when relatives are viewed as helpful sources of additional information to help the professional grasp the overall clinical picture, rather than being seen as invaluable partners in the therapeutic process.

Similarly, in relation to the field of psychiatric nursing, the dominance of the biological perspective is highlighted by research undertaken by the Sainsbury Centre for Mental Health (Warner, Ford & Holmshaw, 1997). In this study a number of mental health nurses working in different NHS Trusts in England were asked to identify the specific skills that they felt were needed by nurses in their work with people with severe psychiatric problems. All of the participants identified dealing with medication as a key area of nursing practice, but few referred to the relevance of psychotherapeutic interventions, and none mentioned family therapy.

The discourses that predominate within the professional world therefore specify the importance of biological factors and minimize the significance of personal relationships or social context. These professional discourses influence, and in turn are influenced by, the dominant beliefs and discourses within wider society regarding mental health problems. The assumptions that professionals hold when they enter a situation of crisis may therefore be strongly influenced by these discourses, and may serve to amplify the process of closure by inviting the professionals to view the crisis situation in terms of an illness process which is located within one of the people involved.

The process of closure also makes itself felt in the lives of the professional concerned. Scott (1995, p. 6) comments:

> 'We become imprinted in the same manner that we have imprinted closure in the patient. This shows up in psychiatric practice where we are almost exclusively drawn to the negative, to what is wrong and commonly fail to realize the primary importance of positive feeling. This is an imprint of the closed attitude. It runs throughout psychiatry'.

Or, as Deegan (cited in Rosen, 1994) puts it, when mental health professionals stop seeing patients as people, we become a bit less human ourselves.

Having considered the influence of these dominant discourses regarding psychiatric disorder within the mental health field and within wider society, I will now discuss some of the factors which may sensitize individual families to the experience of closure.

Familial discourses: the shadow of the ancestor

One example of a type of discourse which may be operational within families and which may sensitize family members to the process of closure has been identified by Scott and Ashworth (1967; 1969) through their work with people in schizophrenia. On the basis of their clinical work and research with families, Scott and Ashworth described certain historical factors which appeared to be a contributory factor in the formation of the problems. In particular, their account focused on the impact on family expectations and relationships when one of the parents has suffered a traumatic experience of losing someone close to them. This loss might entail, for instance, someone close to the parent becoming insane and never recovering; death, or a sudden separation from the person. According to Scott and Ashworth, this loss experience came to profoundly shape the way in which the parent viewed their schizophrenic son or daughter. The person diagnosed as schizophrenic is, in such circumstances, "living under the shadow of their ancestor", in the words of Scott and Ashworth. The catastrophic expectations which are evoked by this constellation of experiences and beliefs provide a context for closure to occur, as the person is viewed as having entered a situation from which there is no return.

An illustration of this process is provided in the following extract from an interview with Christine,[4] who had been admitted to hospital under the Mental Health Act. In this instance, it was Christine's mother who had experienced psychiatric problems in the past from which she was seen as never fully recovering, and this seemed to powerfully shape the manner in which Christine's father responded to his daughter's difficulties:

Alex: *Up until you came into hospital you'd been to see the doctor and so on, and your Dad had been quite concerned to get you into hospital.*

Christine: *Yes, my Dad wanted to get me into hospital, because my Mum, she suffered from really serious post-natal depression, and I think my Dad was thinking, "Deja vu — Christine's got exactly the same as what she had". And that's been some bad experiences that my Dad's had. He had to look after me single-handedly when I was a baby, and my Mum was in hospital for a long period of time. She's got rare blood, or something. My Dad, I think, was thinking that I was going through the same sort of problems as my Mum's got, but I haven't, you know?...*

Alex: *But that was his anxiety?*

Christine: *That was his anxiety — he was thinking, "Oh my God, she's going through exactly what my wife's been through, and I've got to get her into hospital, and I've got to get her fixed". That's what he was saying! .....*

....he was, I think he was just full of fear that I was going to end up like my Mother. Full of fear, because like... my Mother's dependent on tablets, she is. I don't know what it is that's really wrong with her, but she's been taking them for years.

Christine's pregnancy created a context for enormous fears within the family that history would repeat itself. These fears were not only carried by Christine's father, but also her mother and her husband, David:

[4] All names have been changed to protect confidentiality.

Alex: *I was interested in what you were saying earlier — if your Mum had a lot of trouble, problems with post-natal depression....*

Christine: *Yes, she's had post-natal depression, rare blood, I don't know what other problems she's had as well.*

Alex: *Do you think there was a worry somewhere in the background for your Family, if you have a baby, what will it be like for you? Will it be the same as for your Mum, will history repeat itself?*

Christine: *Yeah, when I was pregnant, my Mum was worried sick! She was more worried than I was, she was in absolute state, you know? She was shaking, she was completely worried — whereas I was more relaxed about the whole thing. When I went through the pregnancy even David was in a worse state than me! I said, "Hang on, just chill out! I'm just having a baby, I'm not going to die!".*

The fears that Christine would in some sense be lost to the family if she did not come to be hospital to be "fixed" were so great that attempts by the psychiatric community team to help the family address their concerns outside of hospital through family therapy meetings were unsuccessful. It as only when she entered hospital that these anxieties became allayed.

The potential for hospital admission to exacerbate the process of closure by encouraging and amplifying illness-related discourses is, of course, very great. This relationship between hospitalization and the process of closure will now be considered in more detail.

The impact of hospitalization

The significance of the idea of closure in relation to the experience of psychiatric hospital admission is highlighted by research undertaken by Whittle (1996), which considered the impact of entering hospital on the causal beliefs of the people who were admitted, their families and the staff. Whittle's study suggests that following admission service-users and their relatives became more attached to biological theories of causation, while psychosocial causal beliefs decrease significantly over the period of hospitalization. Whittle suggests that that there was not a similar shift in the causal beliefs of the staff, who in this study were less strongly orientated towards biological beliefs to the exclusion of other factors.[5] He therefore suggests that this change in beliefs for clients and their families may have been linked with wider cultural assumptions about why people need to go into hospital, rather than occurring as a consequence of ideas presented to families by the staff.

Whittle goes on to suggest a link between causal beliefs and treatment beliefs, in that clients who held biological causal beliefs were more likely to regard medication as the

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[5] While the influence of medical narratives is strong throughout the field of psychiatry in the UK, the degree to which particular teams are affiliated to this model will, of course, vary. Other researchers have suggested a mismatch of views between psychiatric professionals and service-users in the opposite direction to that described by Whittle, with professionals orientated towards biomedical perspectives and service-users preferring psychosocial explanations (Johnstone, 1999; Rogers, Pilgrim & Lacey, 1993).

most relevant treatment for their difficulties. The perceived relevance of psychotherapeutic approaches generally, and family or systemically orientated approaches in particular, seemed to diminish for these clients and their families. Hospital admission as a response to a crisis situation may therefore be regarded as a particularly important factor in facilitating a process of closure in relation to interpersonal factors, and in the formation of a 'treatment barrier' where systemically-orientated therapy is concerned.

Within North Tyneside Adult Mental Health Services there has been an attempt to address some of these processes of closure and disconnection through the development of family/staff network meetings which take place shortly after admission. The discussion will now turn towards a consideration of the key theoretical ideas and practice principles associated with these meetings.

Reception Meetings

When a person enters the psychiatric unit within North Tyneside the possibility of arranging a network meeting is discussed with them by a member of the ward nursing team. The meeting will usually occur as soon as possible after admission, and will be attended by the service-user, his or her relatives or significant others [partner, close friends, neighbours], as well as involved professionals from the community and hospital services. We believe that it is generally preferable that a meeting occurs at an early stage during the service-user's stay in hospital, as this is a time when feelings of stress and upheaval may be at their highest. Scharfstein and Libbey (1982) have suggested that during the first few days of admission high levels of anxiety may be experienced by all concerned — the service-user, the family and also the hospital staff, and that this anxiety may result in patterns of distancing or avoidance if not addressed.

The meetings are referred to within the unit as 'reception meetings' in the hope of conveying friendliness to the family. The term 'family therapy' is not used as we wish to avoid unintentionally sending the message to the family that we view them as pathological or that we intend to 'educate' them into a medical understanding of the problem without fully giving credence to their own perspectives and expertize in relation to the situation (Reed, Stevenson & Wilson, 1998).[6] The idea of the meeting is raised with the service-user by the admitting nurse, and information leaflets about the meeting are provided to the person and their significant others. Having written information available hopefully serves both to demystify the meeting for the people who are being invited to attend, and also to simplify the potentially complex convening process for the nursing staff. Convening family or network meetings in an agency setting where more traditional, individually-orientated approaches predominate can be extremely difficult (Burnham, 1986; Treacher & Carpenter, 1989). Staff might feel insufficiently trained or experienced and service-users or relatives might greet the invitation with suspicion —

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[6] The value of holding family/staff meetings at the point of admission has been discussed by several commentators, who have identified benefits in terms of negotiating issues of responsibility (Bruggen & O'Brian, 1984), developing treatment contracts (Treacher, 1984) and furthering the therapeutic dialogue (Rakkolainen, V., Lehtinen, K. & Alanen, Y.O., 1991; Seikkula, 1994).

particularly if they have been in contact with psychiatric services over a period of time and this is the first time that a meeting of this sort has been suggested. Within our service it has been valuable to have a small group of staff who are particularly enthusiastic about the idea of reception meetings who can take a lead role in initiating them, as well as encouraging and supporting those staff who are more uncertain about becoming involved.

The manner in which we conduct the reception meetings has been strongly influenced by the work of the Jaakko Seikkula and his colleagues from the western Lapland area of Finland (Seikkula, 1993; Seikkula, 1994; Seikkula et al., 1995). Theoretical influences which have helped shape the network-orientated approach developed in Finland by Seikkula and his colleagues include ideas about the constructionist nature of language and the dialogical basis of mind, as developed by the Russian literary theorist and philosopher Mikhail Bakhtin (Morris, 1994; Seikkula, 1993). According to this perspective, our individual and social worlds are created in the flow of our outer dialogues with others and our inner dialogues with ourselves. The purpose of the meetings is therefore to shift from polarized or monological accounts of the situation by generating open dialogue between all participants. This includes an attempt to avoid imposing a professional 'authorized account' of the situation onto the family. It is through the process of dialogue, the process of participants hearing and being heard within the meetings, that new accounts and connections can be created.

Attempts to foster genuine dialogue between the different participants in the meetings are, of course, plagued with difficulties in a hospital context where the staff hold great power. This includes formal powers to hold people under the Mental Health Act and forcibly administer medication and other physical 'treatments' as well as the more informal authority or power of professional 'experts' (Andrews, Birch, Reed, Spriddell & Stevenson, 1996). We can, however, aspire towards talking more openly with service-users and those close to them about our ideas and perspectives on their situation, and offer these ideas and perspectives for discussion.

In this endeavour we have found the ideas of Andersen (1990) about reflective processes in therapy to be extremely helpful. Using this approach, some participants in the meeting are invited to share their ideas and reflections about the situation while the others present can listen and then, in turn, offer their own thoughts and reflections. The conversations can move back and forth in this way several times during the meeting, so that participants have the opportunity to be in both talking and listening positions. Thus opportunities to reflect on the conversation are opened and a range of perspectives and suggestions are generated over the course of the meeting.

Within the meetings the staff aim to create a sufficient sense of emotional safety so that participants can share their views in this manner. This requires creating a context in which a degree of uncertainty can be tolerated so that premature decision-making or overly instrumental modes of thinking are minimized. Tolerating uncertainty within meetings can be anxiety-provoking for staff as well as service-users and families, of course, since this position may conflict with professional discourses about being knowledgeable or demonstrating competence by 'having the answers' (Holden, 1990).

These professional anxieties may run particularly high in a hospital setting where service-users and relatives might look to staff to provide hard information about the nature of the problem, the likely outcome, and so on. In order to avoid closing down opportunities for dialogue by adopting an 'Expert position', staff aim to create a climate of safe uncertainty within the meetings. Mason (1993) discusses the importance of shifting from a position of 'unsafe uncertainty' within therapy to a position of 'safe uncertainty':

> *"The position that I am suggesting... is one which I shall call* **safe uncertainty**. *The position is not fixed. It is one which is always in a state of flow, and is consistent with the notion of respectful, collaborative, evolving narrative, one which allows a context to emerge whereby new explanations can be placed* **alongside** *rather than* **instead of**, *or in competition with, the explanations that* clients **and** *therapists bring".* (Page 194)

At the beginning of the meetings, the staff who are responsible for 'hosting' or facilitating the conversation usually explain to those present that there is no pre-constructed agenda for the discussion, and that the time can be used to discuss whatever people feel it is important to talk about. We also explain that the meeting might last for approximately an hour, but that we can end before that time if people wish to do so, so that the people present hopefully feel some control over proceedings, and don't feel that they will be pressurized to continue if the meeting becomes particularly difficult or tense.

While there is no set formula or procedure for the meetings, the staff hosting the meetings tend to keep in mind a very basic structure or series of phases for the discussion:

- Inviting everyone present to introduce themselves, and to say if there is anything in particular they wish to discuss in the meeting
- Discussing the issues that are brought up
- A brief final discussion which entails clarifying any practical issues that need to be carried forward (for instance, issues about leave, medicaiton, or making contact with other services are often raised at some point in the meetings, and it needs to be clarified who will take responsibility for taking these forward after the meeting)

A brief clinical example will now be presented in order to highlight how the process of closure associated with hospital admission was addressed within a reception meeting.

Clinical example

In this example we will return to the situation of Christine, the young woman discussed earlier. Christine had been admitted to the Ward under the Mental Health Act, following a crisis in which her behavior had become increasingly strange and incomprehensible to those around her. Just prior to entering hospital she had become very excited and distressed, and had walked out into the streets near her home one night in her bare feet saying that she was seeking somewhere to sleep. She also described hearing a voice speaking to her from inside her head.

As we have already seen, the initial contact between the family and the community psychiatric team was not successful in resolving the problems without recourse to hospital treatment. Christine's father, Stanley had continued to feel very worried about his daughter and felt strongly that she needed to be in hospital. Stanley was puzzled by the team's emphasis on relationship factors when he believed his daughter to be ill. As a consequence, the situation escalated and there was a continued push for Christine to be admitted, which eventually occurred. Shortly after she entered hospital a reception meeting was arranged on the ward, which was attended by Christine, Stanley, her husband David, the community team psychiatrist [who also acts as hospital doctor], and nurses from the ward and from the community team.

Within the meeting people remained very polarized in their views, and the talk was characterized by a series of conflicting monologues, rather than dialogue. Mechanistic metaphors seemed to abound in the discussion, with talk of Christine's behavior becoming more "controlled", and even of her needing to be "fixed". Christine expressed the view that the problems were strongly connected with gender issues in the family, in particular, she regarded her husband and father as attempting to encourage her into stereotypical roles as a wife and mother. Occasionally, however, Christine would seem to capitulate in the reception meeting, and declare that the situation was her fault as she had been "selfish". David, while expressing the view that Christine was ill and needing hospital treatment, also agreed with Christine that there were tensions in their relationship which needed to be discussed.

Stanley's view of his daughter's situation seemed to be strongly influenced by his experiences when his wife was labeled 'ill' after the birth of Christine. Similarly, his expectations of psychiatric services were shaped by the encounters he had with professionals twenty years previously. He seemed puzzled by the reluctance of the staff to act in accordance with these expectations and provide a biological, illness-based explanation for Christine's actions. There was little sense of dialogue occurring between Christine, her family, and the staff.

The danger of closure occurring and Christine beginning a career as a psychiatric patient was obviously very great in this situation, as the perception that Christine's behavior was a consequence of mental illness rather than a response to a complex and difficult interpersonal situation was reinforced by her admission to the Ward under the Mental Health Act. This view was also likely to be further amplified because of the patriarchal tendency within western culture to regard the expression of anger by women as inappropriate or transgressive and label it as illness (Jones, 1994). Staff in the meeting were therefore careful not to further exacerbate this process this by confirming a medicalised account of the situation. Instead, they proposed the idea that there was a middle view between the position that the difficulties were all of Christine's making, or that they were all the families fault. The staff also attempted to lend credence within the meeting to Christine's view that gender issues within the family needed to be discussed by attending to this aspect of the discussion.

At the close of the reception meeting important differences in perspective between the different participants remained, but it seemed that the possibility of continuing to

explore these had been kept open rather than closed off. Some factors which seemed to assist were:

- Christine felt that her views were listened to by the staff, rather than disregarded as symptomatic of an illness process
- David and Christine received the message from the staff that they would receive ongoing support if they wished to attend future meetings to discuss their relationship
- Stanley was perhaps still puzzled by the position of the staff, but felt reassured that Christine could remain on the Ward until she felt ready to return home. At the same time, the psychiatrist negotiated with Christine that she could commence taking regular leave from the Ward, so that the process of moving on was started
- The presence of the staff at the meeting seemed to create a situation where family members felt able to begin discussing some of these anxieties and differences in a more reflective manner, without the situation becoming heated as it had done previously

In this instance the reception meeting provided a forum where the co-evolving family-professional system could begin a process of dialogue in such a way that possibilities were opened up for further exploration of difficulties. If the meeting had not occurred it is easy to envisage a situation where the experience of entering hospital would have cemented the belief that Christine was 'ill', and that her angry statements about gender were merely symptomatic of this illness. Thus professional intervention would have acted to support patriarchal relationships within the family, silencing dissent and constraining opportunities to re-negotiate these relationship patterns.

Conclusion

When a crisis occurs in a person's life the situation may come to be characterized as psychiatric in nature. Key discourses regarding mental illness which are operational within the broader socio-cultural field, the professional domain, and the interpersonal world of the person in crisis may interact together in such a way as to facilitate a process of closure. The person's life and relationships can becoming increasingly shaped or organized by stereotypical notions of the 'psychiatric patient' — stereotypical ideas, for instance, that the person is lacking in insight, personal agency or responsibility. Admission to hospital can further amplify this process of closing off which occurs.

Hospital admission remains a common professional response to situations of crisis, and the majority of admissions to acute psychiatric units within the UK presently occur on an unplanned crisis or emergency basis (Moore, 1998). When a person does enter hospital, network meetings which include the person defined as ill, their significant others and the staff can provide a useful forum to explore the meanings ascribed to recent events, share ideas and suggestions about ways forward, and generate dialogue between these different participants in the situation. Through this process, connections

between people, ideas, events, memories experiences and so on may be maintained rather than closed off and new connections and possibilities may be created.

Acknowledgement

References

Andersen, T. (1990) (ed.) *The Reflecting Team. Dialogues & Dialogues about the Dialogues.* Kent: Borgmann.

Andrews, J., Birch, J., Reed, A., Spriddell, G. & Stevenson, C. (1996) The Construction of Authority: Context & Power in Family Meetings. *Changes* 14(4), 282–288.

Birch, J. (1991) Towards the restoration of traditional values in the psychiatry of schizophrenias. *Context .* Spring, No. 8, 21–26.

Bruggen, P. & O'Brian, C. (1987) *Helping families: Systems, residential & agency responsibilities.* London: Faber and Faber.

Burnham, J. (1986) *Family Therapy.* London: Tavistock.

Coleman, R. (1999) The politics of the illness. In P. Barker & C. Stevenson (eds) *The construction of power and authority in psychiatry.* Oxford: Butterworth-Heinemann.

Dallos, R., Neale, A. & Strouthos, M. (1997) Pathways to problems: the evolution of 'pathology'. *Journal of Family Therapy* 19(4), 369–400.

Department of Health (Dec. 1998) *Modernising mental health services: Safe, sound and supportive.* Dept. Of Health Publications.

Gergen, K.J., Hoffman, L. & Anderson, H. (1996) Is diagnosis a disaster?: A constructionist trialogue. In Kaslow, F. (Ed) *Relational diagnosis.* USA: Wiley.

Haley, J. (1980) *Leaving Home.* New York: McGraw-Hill.

Holden, R. (1990) Models, muddles and medicine. *International Journal of Nursing Studies* 27(3), 223–234.

Johnstone, L. (1994) Values in human services. *Care in Place* 1(1), 3–8.

Johnstone, L. (1999) Adverse psychological effects of ECT. *Journal of Mental Health* 8(1), 69–85.

Jones, E. (1994) Gender & poverty as contexts for depression. In I. Colgan McCarthy (Ed.) *Human Systems — Special Issue: Poverty & Social Exclusion* 5(3–4), 169–184.

Mason, B. (1993) Towards positions of safe uncertainty. In J. Burnham (Ed.) *Human Systems — Special Issue: Voices from the training context* 4(3–4), 189–200.

Moore, C. (1998) Admission to an acute psychiatric ward. *Nursing Times* 94(2), 58–59.

Morris, P. (1994) *The Bakhtin Reader.* London: E. Arnold.

Parker, I. (1999) Introduction: varieties of discourse and analysis. In I. Parker & the Bolton Discourse Network. *Critical Textwork .* Buckingham: OU Press.

Rakkolainen, V., Lehtinen, K. & Alanen, Y.O. (1991) Needs-adapted treatment of schizophrenic processes: The essential role of family-centred therapy meetings. *Contemporary family Therapy* 13(6), 573–582.

Reed, A. (1998) Manufacturing a human drama from a psychiatric crisis: crisis intervention, family therapy and the work of R. D. Scott. *Journal of Psychiatric & Mental Health Nursing* **5(5)**, 387–392.

Reed, A., Stevenson, C. & Wilson, M. (1998) Social network meetings ease trauma of psychiatric admission. *Nursing Times* **94(42)**, 52–53.

Rogers, A., Pilgrim, D. & Lacey, R. (1993) *Experiencing psychiatry: User's views of services.* London: MacMillan.

Rosen, A. (1994) 100% Mabo: De-colonising people with mental illness and their families. *Australian & New Zealand Journal Of Family Therapy* **Vol. 15, No. 3**, 128–142.

Scharfstein, B. & Libbey, M. (1982) Family orientation: Initiating patients and their families to psychiatric hospitalization. *Hospital & Community Psychiatry* **33(7)**, 560–563.

Scott, R.D. & Ashworth P.L. (1967) 'Closure' at the first schizophrenic breakdown: a family study. *British Journal of Medical Psychology* **40**, 109–145.

Scott, R.D. & Ashworth, P.L. (1969) The shadow of the ancestor: a historical factor in the transmission of schizophrenia. *Brit. Journal of Medical Psychology* **42**, 13–32.

Scott, R.D. (1973) The treatment barrier: Part 1. *British Journal of Medical Psychology* **46**, 45–55.

Scott, R.D. & Starr, I. (1981) A 24-hour family orientated psychiatric and crisis service. *Journal of Family Therapy* **3**, 177–186.

Scott, R.D. (1995) The Barnet Crisis Service. Paper delivered at the 25th anniversary meeting of the Barnet Crisis Service.

Seikkula, J. (1993) The aim of therapy is to generate dialogue: Bakhtin & Vygotsky in family sessions. *Human Systems* **4(1)**, 33–48.

Seikkula, J. (1994) When the boundary opens: family and hospital in co-evolution. *Journal of Family Therapy* **16(4)**, 401–414.

Seikkula, J. et al. (1995) Treating psychosis by means of open dialogue. In S. Friedman (ed.) *The reflecting team in action: collaborative practice in family therapy* New York: Guilford books: New York.

Taylor, P.J. & Gunn, J. (1999) Homicides by people with mental illness: Myth and reality? *British Journal of Psychiatry* **174**, 9–14.

Treacher, A. (1984) Family therapy in mental hospitals. In A. Treacher & J. Carpenter (eds) *Using family therapy.* Oxford: Blackwell.

Treacher, A. & Carpenter, J. (1989) *Problems and solutions in marital and family therapy.* Oxford: Blackwell.

Warner, L., Ford, R. & Holmshaw, J. (1997) Don't just role over and die. *Nursing Times* **93(52)**, 30–31.

White, M. (1993) The politics of therapy: An interview with Michael White by Lesley Allen. *Human Systems* **4(1)**, 19–32.

Whittle, P. (1996) Causal beliefs and acute psychiatric hospital admission. *Brit. Journal of Med. Psychology* **69**, 355–370.

Systemic Approaches to Mental Health Care in Finland

During the summer of 1998 I was lucky enough to spend a few weeks in Finland, in order to learn about the family and social network orientated approaches to mental health practice that have been developed there . Over a couple of years I had become increasingly fascinated by the work which is taking place in Finland, after reading a series of articles by Jaakko Seikkula and his colleagues from the Tornio area which describe both the principles, and the remarkable effectiveness, of their approach (Seikkula, 1993; Seikkula, 1994; Seikkula et al.,1995).

The country has a tradition, dating back to the sixties, of treating people with major psychiatric problems, such as schizophrenia, using family-based approaches in community settings. A national initiative, known as the API Project (Acute Psychosis Integration), began in 1992, in which a number of services serving different catchment areas across the country are developing systemically-orientated treatment approaches for people experiencing psychotic problems (Lehtinen et al.,1996). Psychiatric provision in the UK tends to be individually focused, rely heavily on drugs and hospitalization, and is plagued by problems around differing priorities and perspectives between primary and secondary care professionals. I was therefore very keen to observe at first hand what can be achieved through the consistent application of a systemic approach.

The Tornio team which I visited has been particularly successful in applying systemic principles both in their therapeutic work with service-users, and also in the organization of their service, in order to ensure that their responses are co-ordinated, consistent and adapted to the needs of the person in crisis. The service consists of slightly over 100 staff of different disciplines, serving a population of approximately 70,000 people. The service is distinguished by a number of special features, including the following:

Focus on families and social networks: the team provides a rapid response in crisis situations, with a first meeting being arranged within twenty-four hours of referral. Family members or others close to the service-user are routinely included in discussions about treatment, and the team has a policy of avoiding taking decisions about the service-user outside of his or her presence. Discussion takes place openly between all parties, with the aim of creating collaborative working relationships in which dialogue can freely occur. These network meetings are the primary form of treatment used in this approach.

Emphasis on reflective practice: the team aims to maintain an ethos for the meetings which is thoughtful and reflective. The work of Norwegian family therapist Tom Andersen (Andersen, 1990) regarding reflective processes in family meetings has strongly influenced the team in Tornio. In this approach, participants in the meeting are invited to share their ideas and reflections about what is being discussed, while the others present can listen and in turn offer their own thoughts and reflections. Thus a range of perspectives and suggestions are generated over the course of the meeting. Because the professionals who are present openly share their own ideas and beliefs about the problem for discussion with the service-user and his or her family, staff are less likely to become rigidly attached to unhelpful or judgmental beliefs about the service-user, compared with situations in which much of the discussion between staff and decision-making takes place away from the persons presence.

Seamlessness between hospital and community: one of the most impressive features of the service is the extent to which the hospital and the community staff view themselves as part of the same team. This allows for considerable consistency in situations where a service-user needs to be admitted to hospital for a time. Members of the hospital team participate in meetings which occur in the service user's home, and the community staff attend meetings with the person in hospital. Once a treatment team has been formed around the person seeking help, the membership of this group tends to remain consistent across time. One of the benefits brought about by this inter-weaving of hospital and community staff is that people seem to require much shorter periods of hospital treatment than is the case in the UK.

Minimal use of neuroleptic drugs: as with the other sites participating in the API Project, the team in Tornio use minimal amounts of medication in their work. A two-year follow-up study of people experiencing first episode psychosis has recently been undertaken by the team, which demonstrates that only 22% of service-users required ongoing medication. The majority of those who were medication-free at follow-up had never received any drug treatment. Over 70% of the service-users in the study had also shown good social adjustment over the two-years, and were free from relapse (Seikkula & Alakare, 1998).

Resources and training: the mental health services in Finland are very well resourced by comparison with the UK: the service that I work in, for instance, has approximately the same number of staff as the Tornio team, but serves a population which is more than three times larger. Approximately three-quarters of staff in the team have completed a three year family therapy course, and many of the remaining staff have trained in individual psychotherapy.

Implications for UK services

Which features of the above might successfully transfer to the UK context? Remember that the Finns have not suffered the consequences of a contract culture over recent years, and their services are much better resourced. Many of the tensions that currently exist between primary and secondary care in the UK regarding service priorities etc. are, I think, linked to the fact that we have been starved of cash for so long. There are also many cultural, social and geographical differences between the two countries.

Systemic approaches to mental health care might provide practical means to overcome many of the difficulties associated with the more reductionist, individually-focused practices that predominate in the UK. Readers of TF will be extremely familiar with the vicious cycle that occurs when an individual is identified as mentally ill, removed from their usual social context, treated in hospital, then returned to similar social circumstances at a later date. Families and carers also frequently complain about feeling ignored and excluded by mental health professionals, and co-ordination between primary, secondary and voluntary care staff is still frequently plagued by problems of poor communication, despite the Care Programme Approach. The systemically-orientated approach which has been developed in Finland shows that social network meetings are an ideal vehicle for developing new ideas, understandings and solutions in a manner which is inclusive and collaborative.

Innovative practitioners here in the UK have also shown that crisis intervention approaches which focus on involving the service-users family or social network can reduce the need to bring people into psychiatric hospital and help prevent chronicity (Scott,1980). At a time when there is such emphasis on ideas about evidence-based practice it would seem irresponsible to ignore the potential contribution of these systemic approaches that have been shown to be so effective.

References

Andersen, T. (1990) (ed.) The reflecting team: dialogues & dialogues about the dialogues. Borgmann, Kent.

Lehtinen, V., Aaltonen, J., Koffert, T., Rakkolainen, V. Syvalahti, S. & Vuorio, K. (1996) Integrated treatment model for first-contact patients with a schizophrenia-type psychosis: the Finnish API Project. Nordic Journal of Psychiatry, 50: 281-287.

Scott, R. D. (1980). A family orientated service to the London Borough of Barnet. Health Trends, 12, 65-68.

Letter from Israel

Family medicine in Israel has gone through a rapid process of development in recent years (Weingarten & Lederer, 1995). The introduction of a four-year vocational training program has created many 'specialists in family medicine', a title that, despite the apparent contradiction in terms, distinguishes between trained specialists and untrained GPs – the latter still being the majority of primary care physicians in Israel. A fundamental part of the definition of this new discipline is being not-only-a-bio-medical doctor. Accordingly, one of the essential components of the training programme is introducing GP trainees, who are socialised in the traditional bio-medical model during their undergraduate studies, to a more humanistic approach. This goal is approached by introducing them to the biopsychosocial model, with courses on psycho-social issues in practice, co-tutoring by social workers, offering Balint groups, and requiring a presentation of one family intervention as part of the final qualification examination.

Last year I was tremendously fortunate to spend time off my practice and teaching duties in Israel and to attend the training course for systemic general practice ('Working with families and teams – introduction to systems-based approaches in general practice' taught by Drs Caroline Lindsey and John Launer at the Tavistock Clinic (Launer and Lindsey, 1997). Earlier this year, Caroline and John were kind enough to come to north Tel Aviv and to teach the first ever workshop on systemic ideas for family doctors at the Department of Family Medicine at the University. Not surprisingly for those of us who know Caroline and John, the workshop was a huge success. Participant feedback suggested that systemic ideas address needs, maybe unidentified before, for better interviewing skills and for a conceptual framework for the work of family doctors.

The seed of systemic ideas has fallen on favourable ground in Israel: not a dry land of strict biomedical doctors, but the well-cultivated soil of vocationally-trained doctors who were well aware of the impact of familial and social factors on disease, but who also felt that the biopsychosocial model may not have all the answers. Doctors seeking to enlarge their repertoire of working methods found the method of asking circular questions very helpful and effective. Doctors who are trainers and teachers discovered that the new interviewing techniques were useful for working with trainees as well as with patients. However, systemic training offers more than teaching interviewing skills. During the Tavistock course, the participants had started motivated to learn how to interview families, but soon moved on to seeing wider implications of systemic ideas (Launer & Lindsey, 1997).

So what does systemic thinking, and in particular social constructionism, have to offer to Israeli family doctors? Some of the attractions of social constructionism to general practice are universal: it offers us an opportunity to look at ourselves as therapists, and it has the potential to liberate us from the constant urge to solve problems (Launer, 1996; Launer, 1995). I see some of the attractions especially relevant for the Israeli scene as follows:

1. The concept of the family doctors role as an elicitor of alternative patient stories (stories that make sense from the patients point of view) is particularly appealing for doctors who live in a multi-cultural society like Israel. The idea that these stories can exist side by side with the bio-medical explanation helps doctors not to feel threatened by these novel ideas.

2. The culture in Israel is less formal than in Britain and there is less distance between doctors and patients. Patients may explicitly make demands that might have stayed unspoken in similar consultations in Britain (Launer, 1995). Some doctors see this behaviour as a threat to their power (another central issue for social constructionists) and many look for ways to deal with the stress that arises from these situations. Looking at these consultations via a social constructionist lens may help by including the doctor's views, medical beliefs and background in the picture; the doctor's tension may decrease by moving the focus to the interaction between the doctor's beliefs and those of the patient during the consultation.

What are the prospects for systemic training in Israel? In the future, we need to identify and define better the specific needs of family doctors in Israel, and to check out what aspects of systemic training are most helpful for us. How are our needs different from the needs of our British colleagues? Can we build a framework that will bring together Israeli family doctors and family therapists? Should we offer systemic training only for qualified specialists in family medicine, or would it work as well at the vocational training level, where we can offer courses in a structured setting which already exists. Currently we are trying to keep up the systemic spirit and to explore some of these questions in regular meetings of a group of interested family doctors (co-lead by Amnon Toledano, a family therapist and yet another Tavistock graduate).

Enthusiasm is epidemic. I had caught the enthusiasm for systemic ideas at the Tavistock, and was delighted to see it spreading in Israel, suggesting that borders do not restrict the relevance of systemic ideas for general practice.

Let's keep up the dialogue!

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References
Launer, J. (1995) A Social Constructionist Approach to Family Medicine. *Family Systems Medicine*, 13, 379-389.
Launer, J. (1996) You're the Doctor, Doctor! Is Social Constructionism a Helpful Stance in General Practice Consultations? *Journal of Family Therapy*, 18, 255-267.
Launer, J. & Lindsey, C. (1997) Training for Systemic General Practice: A New Approach from the Tavistock Clinic. *British Journal of General Practice*, 47, 453-456.
Weingarten, MA. & Lederer, J. (1995) The Development of Family Medicine in Israel. *Family Medicine*, 27, 599-604.

Seikkula, J. (1993) The aim of therapy is to generate dialogue. *Human Systems*, 4, 1, 33-48.
Seikkula, J. (1994) When the boundary opens: family & hospital in co-evolution. *Journal of Family Therapy*, 16, 4, 401-414.
Seikkula, J. et al. (1995) Treating psychosis by means of open dialogue. In Friedman, S. (Ed.) *The reflecting team in action: collaborative practice in family therapy*. Guilford Books, New York.
Seikkula, J. & Alakare, P. (1998) Open dialogue in first episode psychosis: a two-year follow-up. [Unpublished Paper].
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counsellors have always had as part of their work..

Some people may think that all of this is far too complicated and that much simpler one-to-one therapy or more direct approaches will suffice. We agree. If you have a way of doing things which is more traditional and it works then use it. If it ain't broke – don't fix it. We are proposing this way of working when the old ways do not work. Nor is it meant to be a recipe. Everyone should start from where they are, with the people they work with, and think how they might just take one small step forward.

Jack Czauderna, GP in Sheffield, and
Sara Barratt, family therapist in London
References
Doherty, W. (1995) The Whys and Levels of Collaborative Family Health Care. *Family Systems Medicine*, 13, 275-281.
Seaburn, D., Lorenz, A., Gunn, W., Gawinski, B., Mauksch, L., (1996) *Models of Collaboration*. Basic Books.

Social network meetings ease trauma of psychiatric admission

The first few days can be crucial in breaking down the boundaries between psychiatric unit and service-user. Alex Reed, Mike Wilson and Chris Stevenson explain

Entering psychiatric hospital may have profound consequences for the person concerned as well as for their family or friends.

The processes by which a person loses their identity and becomes 'the patient' when entering a psychiatric hospital are well documented. Close relationships may be strained, and opportunities for staff and families to collaborate may be lost.

Relatives may be left with a sense that their opinions and needs are unacknowledged by staff, leading to feelings of dissatisfaction and resentment.

Staff associated with the inpatient unit in North Tyneside Mental Health Services have attempted to address these problems. Shortly after a person enters hospital they arrange 'social network' meetings.

Known within the unit as 'reception meetings', they are attended by the service-user, a member of the service-user's primary nursing team from the ward and 'significant others' of the patient's choosing. As well as relatives and/or close friends, this might include professionals from outside the hospital team who are involved in the person's care.

The manner in which families are invited to attend the meeting requires careful thought and sensitivity on the part of the staff hosting the meeting, so that family members do not get the impression that they are being asked along because they are viewed as pathological. Relatives will be deterred from attending if they suspect that the professionals subscribe to family-blaming theories of psychiatric disorder, or that the staff wish to 'educate' them into a medical understanding of the problem without fully giving credence to the family's perspectives and expertise in relation to the situation.

Rather than treating families as objects of change, reception meetings emphasise the contribution of families as agents of change, whose ideas and support are invaluable resources within the therapeutic process.

Staff hosting the meetings try to engender a friendly atmosphere. To ensure patients and their families are active participants, the hosts pay particular attention to language, avoiding professional jargon. There is an acceptance that everyone present has a contribution to make. The meetings do not have an agenda so as to allow space for the participants to determine the areas they want to talk about.

Reception meetings at the ward provide a forum to:
■ Tell the history of events leading up to the admission;
■ Express emotions;
■ Talk of fears about the severity of the problems and about their involvement with psychiatry;
■ Allow the family to inform and educate the staff about their culture;
■ Explore myths about mental illness and psychiatry;
■ Find out from staff about the ward and general aspects of the service such as staff roles, how decisions are taken in the unit, and so on;
■ To ask questions, express concerns or dissatisfactions with the service;
■ Make plans;
■ Raise difficult topics between family members;
■ Discuss actual or potential issues of stigma or discrimination that the service-user or family might encounter as a consequence of the admission;
■ Discuss practical arrangements.

The collaborative ethos of the meetings is helped by an avoidance of any diagnostic or agenda-setting discussion among the professionals beforehand. In more traditional care-planning or therapy forums, the professionals often meet together before the session to generate opinions and theories about the service-user. But the danger in this arrangement is that the professional may become too attached to a line of questioning and fail to take on board the different versions of events that other people hold.

Staff hosting the reception meetings take responsibility for encouraging different points of view, even though this may be difficult for some participants. For instance, professionals may be disconcerted by the invitation to share their ideas and opinions openly in the presence of the client if they work in settings where this rarely happens.

The conversations that occur in the meetings are often reflective in style and a premature focus on problem-solving or task-orientated discussion tends to be avoided.

Telling one's story can be validating in its own right. When a diversity of views is available, there is more opportunity for dialogue, rather than the imposition of a single account. The aim of staff is to structure the conversation so that each of those involved has the chance to talk about the situation from his or her perspective, while at the same time guiding the conversation so

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Cultural diversity in admissions

Hassina Khatun is a Bangladeshi woman in her early twenties who was admitted to the ward in a psychotic state.

A reception meeting was arranged soon after admission, which was attended by her parents, a community worker who had been closely involved in helping her, a member of the inpatient primary nursing team, and an interpreter.

The meeting was hosted by two members of the family team. The hospital team had very little experience or knowledge of Bangladeshi culture, and so this reception meeting provided an opportunity for the family to inform and educate the staff about Muslim family structure and traditions.

The information shared was crucial to Ms Khatun's stay in hospital, such as the importance of examinations being carried out by a female doctor and not arranging meetings on days of religious observance for Muslims.

The Harpers find out about hospital culture

Patrick Harper was admitted to the ward experiencing profound feelings of depression. The reception meeting was attended by Mr Harper and his partner, plus his primary nurse from the inpatient team and two members of the family team who were responsible for hosting the event.

Mr Harper had never been in psychiatric hospital before and was very nervous. His primary nurse said that she had noticed that during the brief time he had been there he had tended to isolate himself, avoiding other service-users and the staff.

Both Mr Harper and his partner were puzzled by the roles of the

nursing and medical staff, and the processes by which decisions about his care would be made while he was in hospital. The reception meeting allowed staff to explain their roles and the ward structure, while also providing an important opportunity for the couple to tell the story of the events leading up to the admission in some detail.

As a result of the meeting, Mr Harper felt much more relaxed in the unit, his partner felt more connected with the staff team, and both felt clearer about the ways in which the staff could help them address the difficulties that led to admission.

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that everyone also listens and reflects on what is being said.

Conclusion

The process of admission has traditionally followed a set pattern which centred on the individual service-user. Reception meetings are one way of including the person's family, carers or close friends in this process.

These meetings have proved to be particularly useful in helping to clarify issues of concern at the initial stage of a person's stay in hospital, thus helping to demystify those elements surrounding admission which are potentially frightening or disempowering.

This early contact between the staff team and the people who are close to the service-user adds to the quality of collaboration and enables meaningful dialogue to develop in a manner which can transform the nature of admission and create a focus for change. **NT**

Andersen, T. (1987) The reflecting team: dialogue and meta-dialogue in clinical work. *Family Process;* 26: 4, 415–428.

Fox, N. (1997) Texts, frames and decisions over discharge from hospital: a deconstruction. *Social Sciences in Health;* 3: 1, 41–51.

Scott, R. D. (1973) The treatment barrier: Part 1.

British Journal of Medical Psychology; 46: 1, 45–55.

Seikkula, J. et al. (1995) Treating psychosis by means of open dialogue. In: Friedman, S. (ed.) *The Reflecting Team in Action.* New York: Guildford Press.

Winefield, H.R., Burnett, P.L. (1996) Barriers to an alliance between family and professional caregivers in chronic schizophrenia. *Journal of Mental Health;* 5: 3, 223–232.

The names of the service-users have been changed

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References:

Alanen, Y.O. (1997) *Schizophrenia: It's origins and need-adapted treatment.* London: Karnac.

Alvesson, M. & Skoldberg, K. (2000) *Reflexive methodology: New vistas for qualitative research.* London: Sage.

Andersen, T.(1990) (ed.) *The reflecting team: Dialogues and dialogues about the dialogues.* Kent, UK: Borgmann.

Andersen, T. (1992) Relationship, language and pre-understanding in the reflecting process. *Australian and New Zealand Journal of Family Therapy.* 13(2): 87-91.

Andersen, T. (1993a) See and hear, and be seen and heard. In S. Friedman (ed.) *The new language of change.* New York: Guilford.

Andersen, T. (1993b) Commentary on Alex Reed's article, "The reflecting team in a systemic therapy training context". *Human Systems.* 4(3-4): 229-230.

Andersen, T. (1995) Reflecting processes; Acts of informing an forming: You can borrow my eyes, but you must not take them away from me! In, S. Friedman (Ed.) *The reflecting team in action: Collaborative practice in family therapy.* New York: Guilford Press.

Andersen, T. (2002) Blinding and deafening moments and threatening futures: In the wake of September 11th 2001. *Family Process.* 41(1): 11-13.

Anderson, H. (1997) *Conversation, language & possibilities: A postmodern approach to therapy.* New York: Basic books.

Anderson, H. (2001) Postmodern collaborative and person-centred therapies: what would Carl Rogers say? *Journal of Family Therapy.* 23(4): 339-360.

Anderson, H. (2002) In the space between people: Seikkula's open dialogue approach. *Journal of Marital & Family Therapy.* 28(3): 279-281.

Anderson, H. & Goolishian, H. (1988) Human systems as linguistic systems: Preliminary & evolving ideas about the implications for clinical theory. *Family Process.* 27: 371-393.

Anderson, H. & Goolishian, H. (1992) The client is the expert: a 'not-knowing' approach to therapy. In, S. McNamee and K.J. Gergen (eds) *Therapy as social construction.* London: Sage.

Andrews, J., Birch, J., Reed, A., Spriddell, G. & Stevenson, C. (2000) The construction of authority: Context & power in family meetings. In P. Barker & C. Stevenson (eds.) *The construction of power and authority in psychiatry.* Oxford: Butterworth Heinemann.

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Annells, M. (1999) Evaluating phenomenology: Usefulness, quality and philosophical foundations. *Nurse Researcher.* 6 (3): 5-19.

Attneave, C.L. (1990) Core network intervention: An emerging paradigm. *Journal of Strategic & Systemic Therapies.* 9(1): 3-10.

Baggini, J. (2002) Postmodernism R.I.P. *The Philosophers' Magazine.* 20: 36.

Bateson, G. (1978) *Steps to an ecology of mind.* 2nd edition. London: Paladin.

Bateson, G. (1988) *Mind and nature: A necessary unity.* 4th edition. New York: Bantam Books.

Bender, C. (1998) Bakhtinian perspectives on 'everyday life' sociology. In M. Mayerfield Bell & M. Gardiner (eds.) *Bakhtin and the human sciences.* London: Sage.

Birch, J. (1991). Towards the restoration of traditional values in the psychiatry of schizophrenias. *Context.* Spring, No. 8: 21-26.

Birch, J. (1995) Chasing the rainbow's end and why it matters: A coda to Pocock, Frosh and Larner. *Journal of Family Therapy.* 17(2): 219-228.

Birch, J. (1996) The SMI nurse. *Journal of Psychiatric & Mental Health Nursing.* 3(4): 273-274.

Bonner, A. & Tolhurst, G. (2002) Insider-outsider perspectives of participant observation. *Nurse Researcher.* 9(4): 7-19.

Boscolo, L. & Bertrando, P. (1993) *The times of time: A new perspective on systemic therapy and consultation.* New York: Norton.

Bott, D. (2001) Client-centred therapy and family therapy: a review and commentary. *Journal of Family Therapy.* 23(4): 361-377.

Bowles, N. (2002) A solution-focused approach to engagement in acute psychiatry. *Nursing Times.* 98(48): 26-27.

Brown, L.M. & Gilligan, C. (1992) *Meeting at the crossroads: Women's psychology and girl's development.* New York: Ballentine.

Browne, D. (1995) Sectioning: The black experience. In, S. Fernando (ed.) *Mental health in a multi-ethnic society.* London: Routledge.

Bruggen, P. & O'Brian, C. (1987) *Helping families: Systems, residential & agency responsibilities.* London: Faber and Faber.

Bruner, J. (1990) *Acts of Meaning.* Harvard: USA

Buber, M. (2000) *I and Thou.* (3rd edition). New York: Scribner Classics.

Burnham, J. (1986) *Family therapy: First steps towards a systemic approach.* London: Tavistock.

Burr, V. (1995) *An introduction to social constructionism.* London: Routledge.

Carers Advisory Group for Mental Health in London (2002) *Working with carers: The London mental health carers' charter.* www.virtuall.org

Carpenter, J. (2002) *Family therapy in adult mental health services: Why bother?* Presentation for Family Therapy Network conference, Newcastle, North Tyneside & Northumberland Mental Health NHS Trust.

Carpenter, J. & Treacher, A. (1989) *Problems and solutions in marital and family therapy.* Oxford: Blackwell.

Carr, A. (1991) Power and influence in systems consultation. *Human Systems.* 2: 15-29.

Cecchin, G. (1987) Hypothesizing, circularity and neutrality revisited: An invitation to curiosity. *Family Process.* 26(4): 405-414.

Cecchin, G. (1993) Prisoners of identity. In conversation with Desa Radovanovic. *Human Systems.* 4(1): 3-18.

Cecchin, G. (2000) Foreword. In E. Jones & E. Asen & *Systemic couple therapy and depression.* London: Karnac Books.

Cecchin, G., Lane, G. & Ray, W.A. *The cybernetics of prejudices in the practice of psychotherapy.* London: Karnac.

Clark, C.C., Scott, E.A., Boydell, K.M. & Goering, P. (1999) Effects of client interviewers on client-reported satisfaction with mental health services. *Psychiatric Services.* 50(7): 961-963.

Colgan McCarthy, I. (1994) Editorial. *Human System: Special Issue: Poverty & Social Exclusion.* 5(3-4): 127-130.

Colgan McCarthy, I. & O'Reily Byrne, N. (1995) A spell in the Fifth Province: It's between meself, herself, yerself, and yer two imaginary friends. In S. Friedman (ed.) *The reflecting team in action: Collaborative practice in family therapy.* New York: Guilford Press.

Cooklin, A.I. (1974) Exploration of the staff-patient 'contract' in an acute female admission ward. *British Journal of Medical Psychology.* 47: 321-335.

Cooperrider, D.L. & Srivastva, S. (1987) Appreciative inquiry in organizational life. In W.A. Pasmore & R.W. Woodman (eds.) *Research in organizational change & development (Vol. 1).* Greenwich CT: JAI Press.

Dallos, R. & Draper, R. (2000) *An introduction to family therapy: Systemic theory and practice.* Buckingham: OU Press.

Dallos, R., Neale, A. & Strouthos, M. (1997) Pathways to problems: the evolution of 'pathology' *Journal of Family Therapy.* 19(4): 369-400.

Davies, J. (1995) A study of family networks and relationships in community networks. In J. Reed & S. Proctor (Eds.) *Practitioner research in health care: the inside story.* London: Chapman & Hall.

Davis, K. (1994) What's in a voice? Methods and metaphors. *Feminism & Psychology.* 4(3): 353-361.

Denscombe, M (1998) *The good research guide: for small scale research projects.* Buckingham: OU Press.

Denzin, N.K. & Lincoln, Y.S. (1998) Introduction: Entering the qualitative field. In N.K. Denzin & Y.S. Lincoln (eds.) *Collecting and interpreting qualitative materials.* California: Sage.

Department of Health (1996) *Building bridges: A guide to arrangements for inter-agency working for the care & protection of severely mentally ill people.* London: HMSO.

Department of Health (1999a) *National Service Framework for Mental Health.* London: HMSO. Available on line: www.doh.gov.uk/nsf/mentalhealth.htm

Department of Health (1999b) *Mental health nursing: Addressing acute concerns.* Report by the Standing Nursing and Midwifery Advisory Committee (SNMAC). London: HMSO.

Department of Health (1999c) *Practitioner guidance: Safe and supportive observations of patients at risk.* Report by Standing Nursing and Midwifery Advisory Committee (SNMAC). London: HMSO.

Department of Health (1999d) *Caring about carers: A National strategy for carers.* London: HMSO.

Department of Health (2002) *Mental health policy implementation guide: Adult acute inpatient care provision.* London: HMSO.

Duggan, M. (1997) *Pulling together: The future roles and training of mental health staff.* London: Sainsbury Centre for Mental Health.

Dwiveldi, K. (ed.) (1999) *Sowing the seeds of cultural competence: Family therapy training for a multi-ethnic society.* The report of the CONFETTI working party on 'Race', Ethnicity & Culture in Family Therapy Training. *Context.* 44.

Eagleton, T. (2003) Pedants and partisans. *Guardian newspaper.* 22nd February. p.33.

Eraut, M. (1994) *Developing professional knowledge and competence.* London: Falmer Press.

Fadden, G. (1997) Implementation of family interventions in routine clinical practice following staff training programmes: A major cause for concern. *Journal of Mental Health*. 6 (6): 599-612.

Fernando, S. (1995) (ed.) *Mental health in a multi-ethnic society*. London: Routledge.

Fernando, S. (2000) Imperialism, racism and psychiatry. In P. Barker & C. Stevenson (eds.) *The construction of power and authority in psychiatry*. Oxford: Butterworth Heinemann.

Field, P.A. & Morse J.M. (1985) *Nursing research: The application of qualitative approaches*. London: Croom Helm.

Flaskas, C. (2002) *Family therapy beyond postmodernism*. Hove: Brunner: Routledge.

Flick, U. (1998) *An introduction to qualitative research*. London: Sage.

Fox, N. (1997) Texts, frames & decisions over discharge from hospital: A deconstruction. *Social Sciences in Health*. 3 (1): 41-51.

Fox, N. (1999) *Beyond health: postmodernism and embodiment*. London: Free Association Books.

Furman, B. & Ahola, T. (1992) *Pickpockets on a nudist camp: The systemic revolution in psychotherapy*. Adelaide: Dulwich Centre Publications.

Geertz, C. (1993) *The interpretation of cultures*. London: Fontana Press.

Geist, P. & Dreyer, J. (1993) The demise of dialogue: A critique of medical encounter ideology. *Western Journal of Communication*. 57: 233-246.

Gergen, K. J. (1985) The social constructionist movement in modern psychology. *American Psychologist*. 40: 266-275.

Gergen, K. J. (1991) *The saturated self: Dilemmas of identity in contemporary life*. New York: Basic Books.

Gergen, K.J. (1999) *An invitation to social construction*. London: Sage.

Gergen, K.J., Hoffman, L. & Anderson, H. (1996) Is diagnosis a disaster?: A constructionist trialogue. In F. Kaslow (Ed) *Relational diagnosis*. USA: Wiley.

Gilligan, C. (1994) Afterword: The power to name. *Feminism & Psychology*. 4(3): 420-424.

Glaze, J. (2002) Ph.D. study and the use of a reflective diary: A dialogue with self. *Reflective Practice*. 3(2): 153-166.

Goffman, E. (1968) *Asylums*. Harmondsworth: Penguin.

Good, P. (2001) *Language for those who have nothing: Mikhail Bakhtin & the landscape of psychiatry*. New York: Kluwer Academic Press.

Goodwin, I., Holmes, G., Nenes, C. & Waltho, D. (1999) A qualitative analysis of the views of in-patient mental health service-users. *Journal of Mental Health.* 8(1): 43-54.

Goolishian, H. & Winderman, L. (1988) Constructivism, autopoiesis & problem-determined systems. *The Irish Journal of Psychology.* 9(1): 130-143.

Gorell Barnes, G., Down, G. & McCann, D. (2000) *Systemic supervision: A portable guide for supervision training.* London: Jessica Kingsley.

Gremmen, I. (1994) Struggling at the crossroads. *Feminism & Psychology.* 4(3): 362-366.

Haley, J. (1975) Why a mental health clinic should avoid family therapy. *Journal of Marriage & Family Counselling.* 1:3-13.

Haley, J. (1980) *Leaving home: The therapy of disturbed young people.* New York: McGraw-Hill.

Hammersley, M. (1992) *What's wrong with ethnography?* London: Routledge.

Harbin, H.T. (1979) A family-orientated psychiatric in-patient unit. *Family Process.* 18: 281-291.

Harbin, H.T. (ed.) (1982) *The psychiatric hospital and the family.* New York: Spectrum.

Harre, R. (1997) Postmodernism in psychology: Insights and limits. *The New Psychologist.* April Edition. 23-28.

Hart, E. & Bond, M. (1995) Developing action research in nursing. *Nurse Researcher.* 2(3): 4-14.

Hatfield, A. B. (1983) What families want of family therapists. In McFarlane W. R. (ed.) *Family therapy in schizophrenia.* New York: Guilford Press.

Hawkes, K., Hopkins, C. & Reed, A. (2001) Finding the centre of the cyclone: reflective family work in a crisis intervention team. *Mental Health Practice.* 5(4): 14-17.

Heritage, J. (1997) Conversation analysis and institutional talk: Analyzing data. In, D. Silverman (ed.) *Qualitative research: Theory, method and practice.* London: Sage.

Hermans, H. (1999) The poyphony of the mind: A multi-voiced and dialogical self. In J. Rowan & M. Cooper (eds.) *The plural self: Multiplicity in everyday life.* London: Sage.

Hill, B. & Michael, S. (1996) The human factor. *Journal of Psychiatric & Mental Health Nursing.* 3(4): 245-248.

Hoffman, L. (1993) *Exchanging Voices* London: Karnac.

Hoffman, L. (2002) *Family therapy: An intimate history.* New York: WW Norton.

Holliday, A. (2002) *Doing and writing qualitative research.* London: Sage.

Holma, J. & Aaltonen, J. (1995) The self-narrative & acute psychosis. *Contemporary Family Therapy.* 17(3): 307-316.

Holquist, M. (1990) *Dialogism: Bakhtin and his world.* London: Routledge.

Hudson, P. (1995) Workshop. DCP South-West Annual Meeting, Wonford Hospital, Exeter.

Hunter, K. (2002) Chain reaction. *Guardian Newspaper,* 4th September, pp. 159-160.

Jencks, C. (1992) The post-modern agenda. In C. Jencks (ed.) *The post-modern reader.* London: Academy Books.

Johnstone, L. (1994) Values in human services. *Care in Place.* 1(1): 3-8.

Johnstone, L. (1999) Do families cause 'schizophrenia'? Revisiting a taboo subject. In C. Newnes, G, Holmes & C. Dunn (Eds.) *This is madness.* London: PCCS Books.

Johnstone, L. (2001) Mix'n'match? Originally published in, *Open Mind.* July/ Aug. Paper retrieved from the internet, March 2003: http://www.critpsynet.freeuk.com/Mix.htm

Johnstone, L. (2002) *Psychiatry: Still disagreeing.* Originally published in, *Clinical Psychology.* 7: 28-31. Paper retrieved from the internet, January 2002: http://www.critpsynet.freeuk.com/Lucy.htm

Katz, A.M. & Shotter, J. (1996) Hearing the patients 'voice': Towards a social poetics in diagnostic interviews. *Social Sciences Medicine.* 43(6): 919-931.

Kitzinger, C. (1994) The spoken word: listening to a different voice- Celia Kitzinger interviews Carol Gilligan. *Feminism & psychology.* 4(3): 408-419.

Koch, T. & Harrington, A. (1998) Reconceptualizing rigour: the case for reflexivity. *Journal of Advanced Nursing.* 28(4):882-890.

Kvale, S. (1996) *InterViews: An introduction to qualitative research interviewing.* London: Sage:

Laing, R.D. (1967) *The politics of experience.* Harmondsworth: Penguin.

Lang, P., Little, M. & Cronen V. (1990) The systemic professional: Domains of action and the question of neutrality. *Human Systems.* 1(1): 39-56.

Lather, P. (1986) Issues of validity in openly ideological research: Between a rock and a soft place. *Interchange.* 4: 63-84.

Lather, P. (1991) *Getting smart: Feminist research and pedagogy with/in the postmodern.* London: Routledge.

Leavey, G., King, M., Cole, E., Hoar, A. & Johndon-Sabine, E. (1997) First-onset psychotic illness: Patients' and relatives' satisfaction with services. *British Journal of Psychiatry.* 170: 53-57.

Legg, C. & Stagaki, P. (2002) How to be a postmodernist: A user's guide to postmodern rhetorical practices. *Journal of Family Therapy.* 24(4): 385-401.

Lehtinen, V., Aaltonen, J., Koffert, T., Rakkolainen, V. & Syvalahti, E. (2000) Two-year outcome in first-episode psychosis treated according to an integrated model: Is immediate neuroleptisation always needed? *European Psychiatry.* 15: 312-320.

Lewin, K. (1946) Action research & minority problems. *Journal of Social Issues.* 2[4]: 34-46.

Luepnitz, D.A. (1992) Nothing in common but their first names: The case of Foucault & White. *Journal of Family Therapy.* 14(3): 281-284.

Lykes, M.B. (1994) Whose meeting at which crossroads? A response to Brown and Gilligan. *Feminism & Psychology.* 4(3): 345-349.

Lyotard, J.F. (1992) What is postmodernism? In, C. Jencks (Ed.) *The post-modern reader.* London: Academy.

Mansell, C. & Malik, Y. (2000) Working with families in in-patient settings. Published in Conference Proceedings: *Working with families: Making it a reality.* North Birmingham NHS Trust.

Mansheim, P.A. (1989) Working with families in an inpatient psychiatric unit for children: Hospital staff members are family therapists too. *Contemporary Family Therapy.* 11(4): 267- 275.

Mason, B. (1993) Towards positions of safe uncertainty. In J. Burnham (ed.) *Human Systems-Special Issue: Voices from the training context.* 4(3-4): 189-200.

Mason, B. (2002) A reflective recording format for supervisors and trainees. In D. Campbell & B. Mason (eds.) *Perspectives on supervision.* London: Karnac Books.

Mauthner, N. & Doucet, A. (1998) Reflections on a voice-centred relational method: Analysing maternal and domestic voices. In J. Ribbens & R. Edwards (eds) *Feminist dilemmas in qualitative research: Public knowledge and private lives.* London: Sage.

McAdam, E. (1995) Tuning into the voices of influence: The social construction of therapy with children. *Human Systems.* 6(3-4): 171-188.

McAdam, E. & Hannah, C. (1991) Violence-part 2: Creating the best context to work with clients who have found themselves in violent situations. *Human Systems.* 2(3-4): 217-226.

McNamee, S. (2003) *Who is the therapist? A postmodern/discursive look at the role of the professional.* Presentation at Northumbria University, January 2003.

Mental Health Act (1983) London: HMSO.

Meyer, J. (1993) New paradigm research in practice: The trials & tribulations of action research. *Journal of Advanced Nursing.* 18: 1066-1072.

Miles, M.B. & Huberman A.M. (1994) *Qualitative data analysis: An expanded sourcebook.* California: Sage.

Miller, J. & Glassner, B. (1997) The 'inside' from the 'outside': Finding realities in interviews. In D. Silverman (Ed.) *Qualitative Research: Theory, Method & Practice.* London: Sage.

Miller, W.L. & Crabtree, B.F. (1998) Clinical research. In N.D. Denzin & Y.S. Lincoln. (eds.) *Strategies of qualitative inquiry.* Thousand Oaks: Sage.

MIND (2000) *Environmentally unfriendly: Patients' views of conditions on psychiatric wards.* London: MIND publications.

Minuchin, S. (1991) The seductions of constructivism. *Family Therapy Networker.* Sept / Oct: 47-50.

Moore, C. (1998). Admission to an acute psychiatric ward. *Nursing Times.* 94(2): 58-59.

Moore, L. & Savage, J. (2002) Participant observation, informed consent and ethical approval. *Nurse Researcher.* 9(4): 58-69.

Morris, P. (1994) *The Bakhtin reader: Selected writings of Bakhtin, Medvedev, Voloshinov.* London: Arnold.

Muijen, M. (2003) Whose evidence is it anyway? *Health Service Journal.* 20: 18.

National Co-ordinating Centre for NHS Service Delivery and Organization Research and Development (NCCSDO) (2002) *Briefing paper: Services to support carers of people with mental health problems.* Retrieved from the internet Dec.2002. www.sdo.lshtm.ac.uk/mentalhealthcarers.htm

Newman, F. (2000) Does a story need a theory? In F. Fee (ed.) *Pathology and the postmodern: Mental illness as discourse and experience.* London: Sage.

Oliver, C. (1996) Systemic eloquence. *Human Systems.* 7(4): 247-264.

Pakman, M. (1999) Designing constructive therapies in community mental health: Poetics and micropolitics in and beyond the consulting room. *Journal of Marital & Family Therapy.* 25(1): 83-98.

Parker, I. (1989) Discourse and power. In J. Shotter & K.J. Gergen (eds.) *Texts of identity.* London: Sage.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T. & Stowell-Smith, M. (1995) *Deconstructing psychopathology.* London: Sage.

Pearce, W. B. (1992) A camper's guide to constructionisms. *Human Systems* 3 (3): 139-162.

Pearce, W.B. (1994) *Interpersonal communication: Making social worlds.* New York: Harper Collins.

Pearce, W.B. & Littlejohn S.W. (1997) *Moral conflict: When social worlds collide.* California: Sage.

Pearce, W.B. & Pearce, K.A. (1998) Transcendent storytelling: Abilities for systemic practitioners and their clients. *Human Systems.* 167-184.

Pearce, W.B. & Walters, K.A. (1996) *Research methods: A systemic communication approach.* Available from PearceWalters Inc. P.O. Box 620866, Woodside, California 94062.

Penn, P. (1999) Metaphors in regions of unlikeness. *Human Systems.* 10(1): 3-10.

Pocock, D. (1995) Searching for a better story: Harnessing modern and postmodern positions in family therapy. *Journal of Family Therapy.* 17(2): 149-174.

Polkinghorne, D.E. (1992) Postmodern epistemology of practice. In S. Kvale (ed.) *Psychology and postmodernism.* London: Sage.

Pylkkanen, P. (1997) The Finnish National Schizophrenia Project: A strategy for psychotherapeutic treatment and balanced deinstitutionalisation. In C. Mace & F. Margison (eds.) *Psychotherapy of psychosis.* London: Gaskell.

Rakkolainen, V., Lehtinen, K. & Alanen, Y.O. (1991) Needs-adapted treatment of schizophrenic processes: The essential role of family-centred therapy meetings. *Contemporary Family Therapy.* 13(6): 573-582.

Reed, A. (1998) Systemic approaches to mental health care in Finland. *Thinking Families: The Newsletter for Family Therapy & General Practice.* 13: 2-4.

Reed, A. (1999) Psychiatric hospital admission and interpersonal 'closure': Network meetings as a means of countering closure. *Human Systems* 10(1): 35-48.

Reed, A., Stevenson, C. & Wilson, M. (1998) Social network meetings ease trauma of psychiatric admission. *Nursing Times.* 94(42): 52-53.

Reed, J. (1995) Practitioner knowledge in practitioner research. In J. Reed & S. Procter (eds.) *Practitioner research in health care: the inside story.* London: Chapman & Hall.

Reed, J. & Biott, C. (1995) Evaluating and developing practitioner research. In J. Reed & S. Procter (eds.) *Practitioner research in health care: the inside story.* London: Chapman & Hall.

Reed, J. & Ground, I. (1997) *Philosophy for nursing.* London: Arnold.

Reed J. & Procter, S. (1995) *Practitioner research in health care: the inside story.* London: Chapman & Hall.

Reid, A.M., Lang, C.M. & O'Neill, T. (1993) Services for schizophrenic patients & their families: What they say they need. *Behavioural Psychotherapy.* 21: 107-113.

Richardson, L. (1990) *Writing strategies: Reaching diverse audiences.* London: Sage.

Rivett, M. & Street, E. (2003) *Family therapy in focus.* London: Sage.

Rivett, M., Tomsett, J., Lumsdon, P. & Holmes, P. (1997) 'Strangers in a familiar place': the evolution of a family therapy clinic within an in-patient adolescent unit. *Journal of Family Therapy.* 19: 43-57.

Rolfe, G. (1998) The theory-practice gap in nursing: From research-based practice to practice-based research. *Journal of Advanced Nursing.* 28(3): 672-679.

Rolfe, G. (2002) 'A lie that helps us see the truth': Research, truth and fiction in the helping professions. *Reflective Practice.* 3(1): 89-102.

Rose, L.E. (1985) Responses of families to the treatment setting. *Nursing Papers.* 20: 72-84.

Sainsbury Centre for Mental Health (1998) *Acute problems: a survey of the quality of care in acute psychiatric wards.* London: SCMH Publications.

Sainsbury Centre for Mental Health (2002) *An executive briefing on adult acute inpatient care for people with mental health problems.* London: SCMH Publications.

Sampson, E.E. (1989) The deconstruction of the self. In J. Shotter & K.J. Gergen (eds.) *Texts of Identity.* London: Sage.

Sandelowski, M (1991) Telling stories: Narrative approaches in qualitative research. *IMAGE: Journal of Nursing Scholarship.* 23(3): 161-166.

Saukko, P. (2002) Studying the self: From the subjective and the social to personal and political dialogues. *Qualitative Research.* 2(2): 244-263.

Sayce, L. (1998) Stigma, discrimination and social exclusion: What's in a name? *Journal of Mental Health.* 7(4): 331-343.

Scharfstein, B. & Libbey, M. (1982) Family orientation: Initiating patients and their families to psychiatric hospitalization. *Hospital & Community Psychiatry.* 33(7): 560-563.

Schon, D. (1987) *Educating the reflective practitioner.* San Francisco: Jossey Bass.

Scott, R. D. (1973). The treatment barrier: Parts 1 & 2. *British Journal of Medical Psychology.* 46: 45-67.

Scott, R. D. (1995). *The Barnet Crisis Service.* Paper delivered at the 25th anniversary meeting of the Barnet Crisis Service, London.

Scott, R. D. & Ashworth P.L. (1967) 'Closure' at the first schizophrenic breakdown: a family study. *British Journal of Medical Psychology.* 40: 109-145.

Scott, R. D. & Starr, I. (1981). A 24-hour family orientated psychiatric and crisis service. *Journal of Family Therapy.* 3: 177-186.

Seikkula, J. (1993) The aim of therapy is to generate dialogue: Bakhtin & Vygotsky in family sessions. *Human Systems* 4(1): 33-48.

Seikkula, J. (1994) When the boundary opens: Family and hospital in co-evolution. *Journal of Family Therapy.* 16(4): 401-414.

Seikkula, J. (1995) From monologue to dialogue in consultation with larger systems *Human Systems* 6(1): 21-42.

Seikkula, J. (2002) Open dialogue with good and poor outcomes for psychotic crises: Examples from families with violence. *Journal of Marital & Family Therapy.* 28(3): 263-274.

Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keranen, J. & Sutela, M. (1995) Treating psychosis by means of open dialogue. In S. Friedman (ed) *The reflecting team in action: collaborative practice in family therapy.* New York: Guilford books.

Seikkula, J., Alakare, B. & Aaltonen, J. (2000) A two year follow up on open dialogue treatment in first episode psychosis: Need for hospitalization and neuroleptics treatment decreases. *Social & Clinical Psychiatry.* 10(2): 20-29. Russian language version. English language version retrieved from the internet, Nov, 2002.

Seikkula, J., Alakare, B. & Aaltonen, J. (2001) Open dialogue in psychosis 1: An introduction and case example. *Journal of Constructivist Psychology.* 14: 247-265.

Seikkula J. & Sutela, M. (1990) Co-evolution of the family & the hospital: The system of boundary *Journal of Strategic & Systemic Therapies* 9(2): 34-42.

Selvini Palazzoli, M. (1984) Behind the scenes of the organization: Some guidelines for the expert in human relations. *Journal of Family Therapy.* 6: 229-307.

Selvini Palazzoli, M. & Prata, G. (1982) Snares in family therapy. *Journal of Marital & Family Therapy.* 8: 443-450.

Shepherd, G., Murray, A. & Muijen, M. (1994) *Relative values: The differing views of service-users, family carers & professionals on services for people with schizophrenia in the community.* Report published by the Sainsbury's Centre for Mental Health, London.

Shotter, J. (1991) Consultant re-authoring: The 'making' and 'finding' of narrative constructions. *Human Systems.* 2(2): 105-120.

Shotter, J. (1993) *Cultural politics of everyday life: Social constructionism, rhetoric & knowing of the third kind.* Buckingham: Open University Press.

Shotter, J. (1996) *Conversational realities: Constructing life through language.* London: Sage.

Shotter, J. & Billig, M. (1998) A Bakhtinian psychology: From out of the heads of individuals and into the dialogues between them. In M. Mayerfield Bell & M. Gardiner (eds.) *Bakhtin and the human sciences.* London: Sage.

Shotter, J. & Katz. A.M. (1999) 'Living moments' in dialogical exchanges. *Human Systems.* 9: 81-93.

Silverman, D. (1998) The quality of qualitative health research: The open-ended interview and its alternatives. *Social Sciences in Health.* 4(2): 104-118.

Silverman, D. (2000) *Doing qualitative research: A practical handbook.* London: Sage.

Singer, M. (1995) Qualitative research as seen from a Batesonian lens. *The Qualitative Report.* 2(2). On-line Journal: http://www.nova.edu/ssss/QR/QR2-2/singer.html

Smith, G. (1986) Resistance to change in geriatric care. *International Journal of Nursing studies.* 23(1): 61-70.

Smith, G. & Velleman, R. (2002) Maintaining a family work for psychosis service by recognising and addressing the barriers to implementation. *Journal of Mental Health.* 11(5): 471-479.

Speck, R. V. (1998) Network therapy. *Marriage & Family Review.* 27 (1/2):51-69.

Speck, R.V. & Attneave, C.L. (1973) *Family Networks.* New York: Pantheon.

Stanley, D. & Reed, J. (1999) *Opening up care: Achieving principled practice in health and social care institutions.* London: Arnold.

Steier, F. (ed.) (1991) *Research & reflexivity.* London: Sage.

Stevenson, C. & Reed, A. (1996) Editorial. *Journal of Psychiatric & Mental Health Nursing- Special Edition: Postmodernity & Psychiatric Nursing* 3(4): 215-216.

Stratton, P. (1998) Culture in systemic practice. *Human Systems.* 9(3-4): 155-158.

Strauss, A. & Corbin, J. (1994) Grounded theory methodology: An overview. In N. Denzin & Y. Lincoln (eds.) *Handbook of qualitative research.* California: Sage.

Stronach, I. (2002) The space is not yet blank: Anthropologies for a future action research. *Educational Action Research.* 10(2): 291-307.

Swartz, S. (1992) Sources of misunderstanding in interviews with psychiatric patients. *Professional Psychology: Research and Practice.* 23(1): 24-29.

Szasz, T. (2001) The case against psychiatric power. In, P. Barker & C. Stevenson (eds.) *The construction of power and authority in psychiatry.* Oxford: Butterworth-Heinemann.

Tomm, K. (1987) Interventive interviewing part 2: Reflexive questions as a means of self-healing. *Family Process.* 26: 167-183.

Townend, M. & Braithwaite, T. (2002) Editorial. Mental health research- the value of user involvement. *Journal of Mental Health.* 11(2): 117-119.

Treacher, A. (1984) Family therapy in mental hospitals. In A. Treacher & J. Carpenter (eds.) *Using family therapy.* Oxford: Blackwell.

Trimble, D. (2002) Listening with integrity: The dialogical stance of Jaakko Seikkula. *Journal of Marital & Family Therapy.* 28 (3): 275-277.

Vivian-Byrne, S.E. (2001) What am I doing here? Safety, certainty and expertise in a secure unit. *Journal of family Therapy.* 23(1): 102-116.

Vuokila-Oikkonen, P., Janhonen, S. & Nikkonen, M. (2002) Patient initiatives in psychiatric care concerning shame in the discussion in co-operative team meetings. *Journal of Psychiatric & Mental Health Nursing.* 9: 23-32.

Warner, L., Ford, R. & Holmshaw, J. (1997). Don't just role over and die. *Nursing Times* 93(52): 30-31.

Warnke, G. (1987) *Gadamer: Hermeneutics, tradition and reason.* Stanford, California: Stanford University Press.

Waterman, H. (1995) Distinguishing between 'traditional' and action research. *Nurse Researcher.* 2(3): 15-23.

Watkins, M. (1999) Pathways between the multiplicities of the psyche and culture: The development of dialogical capacities. In J. Rowan & M. Cooper (eds) *The plural self: Multiplicity in everyday life.* London: Sage.

Weingarten, K. (1995) Radical listening: Challenging cultural beliefs for and about mothers. *Journal of Feminist Family Therapy.* 7(1/2): 7-22.

Wertsch, J.W. (1991) *Voices of the mind: A sociocultural approach to mediated action.* London: Harvester Wheatsheaf.

White, M. (1995) *Re-authoring lives.* Adelaide, South Australia: Dulwich Centre Publications.

Whiteley, S., Briggs, D. & Turner, M. (1972) *Dealing with deviants.* London: Hogarth Press.

Whittle, P. (1996) Causal beliefs and acute psychiatric hospital admission. *British Journal of Medical Psychology* 69: 355-370.

Wilkinson, S. & Kitzinger, C. (1996) *Representing the other: A feminism and psychology reader.* London: Sage.

Winefield, H. R. & Burnett, P.L. (1996) Barriers to an alliance between family and professional caregivers in chronic schizophrenia. *Journal of Mental Health.* 5(3): 223-232.

Wright, E. R. (1997) The impact of organizational factors on mental health professionals involvement with families. *Psychiatric Services.* 48(7): 921-927.