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**Discovering intra cultural meanings and mutual understandings  
in a hostile place**

By Liam MacGabhann

I am going to talk today about part of the experience of carrying out a participatory action research project in an acute inpatient unit with nurses and patients<sup>1</sup> (*they want ed be called patients*) where we changed practice in relation to improving therapeutic interactions between patients and nurses. I'm not going to talk about the whole research project nor necessarily the overall findings. I am going to talk about how we were able to overcome some of the difficulties in all acute inpatient environments in relation to different cultural meanings, and different understandings between service users and professionals that takes away from the potential for acute inpatient care to provide a healing environment In particular understanding experiences of distress and improving ways to cope or manage this in daily lives. Or even to have that time in hospital where a crisis can result in human interactions that helps people overcome the crisis rather than just tranquilising it or burying the cause, just to be dug up again later on.

First though, because not everyone here will have an experience of acute inpatient care and if you have, it will have been different depending on whether you are a professional, voluntary or involuntary patient or a carer of someone who was a patient, I would like to give a background context.

From the outset I can acknowledge from experience and the research that acute inpatient care is helpful for people from both a psychiatric point of view (e.g. receiving medical treatment), a nursing point of view (have someone to listen and explore experiences and help people to cope) and a patient to patient point of view (sharing experiences and ways of dealing with life and mental distress or illness, or coping with the sometimes inhumane treatment in hospitals).

Unfortunately in many cases this positive experience is marred by so many other negative experiences that it is difficult to find the match to light the candle in the dark. Many of the wonderful initiatives aspired to, promised and planned by government policy - such as partnerships in care, patient choice in treatment, empowering practice etc. don't get to infiltrate the walls of acute inpatient care and a culture that is often more closely resembles the bygone days of custodial institutional care than a modern mental health service. Just a few examples to give us an idea – a singular process for describing peoples experiences (DSM-IV), generally drug treatment is the principle form of treatment with lack of support for meaningful activity and other therapeutic approaches, peoples individuality is whipped away through rules, regulations personal objects taken away and an environment of constant monitoring, control and loss of liberty that induces a sense of complete disempowerment for many, regardless of whether they are voluntary patients or detained.

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<sup>1</sup> The term 'patient' is used in this paper without prejudice. Research in acute inpatient environments frequently uses the term, as that which people choose whilst an inpatient. This was also the choice term of inpatients in this inquiry.

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Clearly professionals do not purposely plan to make life a misery for patients and one might imagine that nurses did not plan to become social police or agents of control when they embarked on a caring career. Equally the psychiatrists who prescribe mind numbing drugs that persistently over the years have been shown to have limited (though useful) effect on their own in dealing with patients distress did not set out to harm patients. No, nurses and doctors generally strive to provide care in the way that they understand it to be effective. A devil on their shoulder and for those who listen and read informs them that all is not right in the way they are treating people and they wonder what to do. Nurses commonly respond to the little devil by 'doing the best they can', pleading disempowerment due to the 'medical model' over riding their autonomy to do different or getting the hell out of such a god awful environment into 'the community' or 'burning out'.

The why is actually quite easy to answer, a bit like 'women are from venus and men are from mars'.

Nurses are socialised into this particular institutional *culture*, not necessarily by choice or design but by being part of a process that self perpetuates itself. Educationalist and researchers are flabbergasted that practice is not changing despite their best efforts to provide evidenced based care, more ethical and values based ways of engaging in practice. Yet for example the newly qualified nurse intent on changing the world with all of the tools for best practice at his or her disposal within six months has been assimilated into the culture of acute inpatient care.

Crucial to the cultural survival and maintaining emotional integrity for them is how nurses along with and on behalf of psychiatrists ascribe *meanings* to people experiences that are admitted to hospital. Regardless of the patients story, they are ascribed a diagnostic label and the more a patient tries to explain or explore meaning for their experiences the more substance is provided for integrating their experience into some pathological condition. For nurses it is good to encounter a person with a relapse of 'schizophrenia due to non compliance with medication'. Because they can look after the person whilst the drugs take the necessary effect and they can hopefully (though often fruitlessly) convince patients to take responsibility for taking their drugs in the future. They do the best they can.

Patients are not necessarily part of this culture, they are often individual people with their own experiences of mental distress, and in crisis either voluntarily or involuntarily trying to make sense of the experience in an environment that has already packaged the experience for them. Left with little choice the patient can argue against the package explaining as best they can that it is not helpful for their understanding of the experience or dealing with it – in time receiving an additional meaning, that of 'difficult patient'. They can play along, having little other choice trying to survive until they get out of there. Learning as they go the best ways to influence the professionals "oh yea I realise now that I must be deluded and need tablets" or

"the voices are going away and I think I can control them now, can I go on leave?". Or as is the case for many, they can become assimilated into the culture themselves taking on whatever role is expected of them to perpetuate a happy medium. Of course they run the risk of losing any notion of what their experience means to them as a person and may even be punished later on for being a 'bed blocker'.

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None of the above is necessary helpful for people or the practitioners trying to provide help but the well preserved institutional process is impermeable to; contamination, cross fertilisation, alternative perspectives and positive change. This has been shown time and time again. Maybe we have to accept that process until such a time as alternatives make it redundant in another era. Or maybe another more helpful process could be lifted into the institution, in parallel though without threatening the status quo?

That was the intention of this research. What I will describe today is some of the methods that were used in the process that allowed us to temporarily get inside the paternalistic culture long enough for the people themselves to question it. And importantly use this time to create a space where meanings could be explored rather than be ascribed and new meanings and understandings could emerge that was to influence how nurses and patients interacted thereafter.

PAR is a form of research usually associated with people who are disempowered and disenfranchised who are trying to overcome this situation. It is usually though not always with a group of people in a similar situation. In our case there was two distinct groups who in their own way were disempowered and disenfranchised by the system, albeit patients clearly way down on the power hierarchy.

PAR and other forms of action research differs from other research in that as well as creating new knowledge it is also a requirement to change the environment at the same time, e.g. in this case to transform nursing practice as it relates to therapeutic interaction with patients.

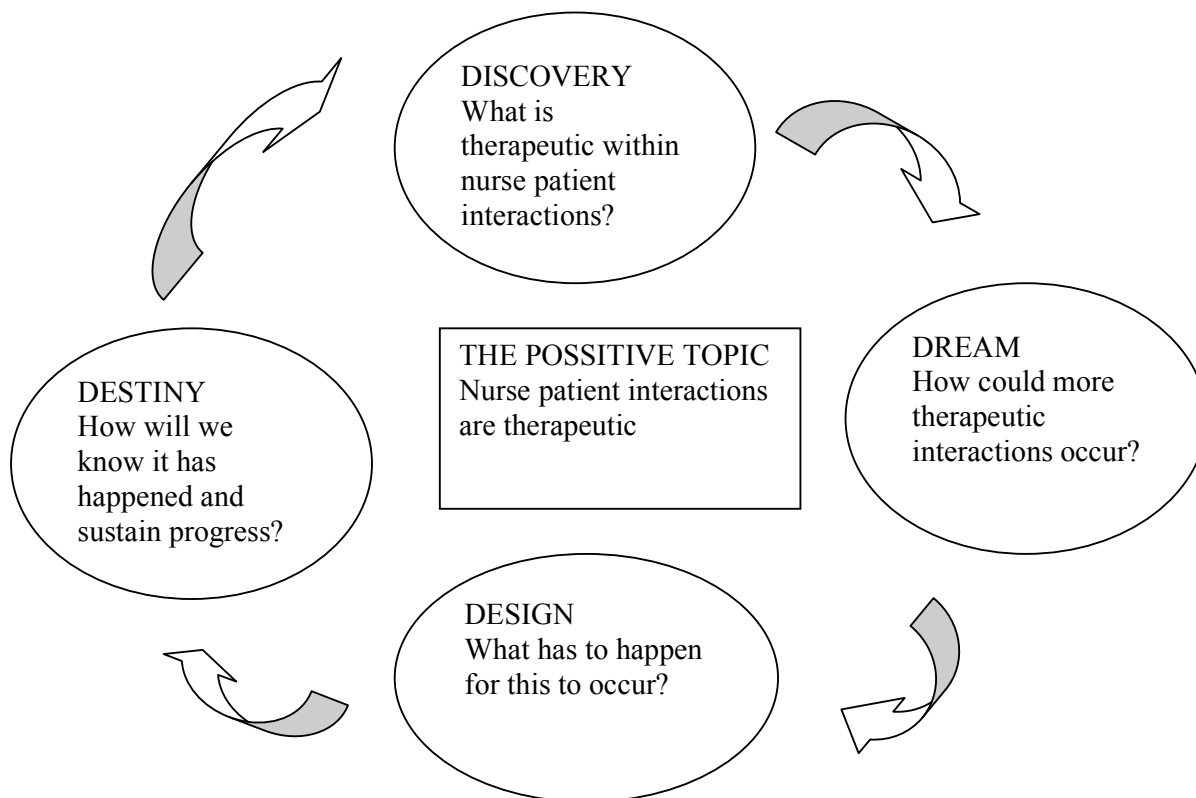
Simply put there are two mechanisms that achieve this. That participants engage in a respectful dialogue that encourages them to critically reflect on their existing circumstances and through collective action change it for the better. Enough of that what did we do?

I am going to summarise four aspects of the research and practice development process that allowed us to discover intra cultural meanings and mutual understandings in this often hostile place.

- (1) Co-participation as genuine partners in the process. This involved a slow process initially in the first cycle of research where nurses and patients separately discussed how therapeutic interaction could be improved. The second cycle was where partnership came into it's own and nurses and patients stepped outside of their comfort zones. A safe non threatening space was necessary for this step where respect for each other, equity of participants, each voice could be heard and people were supported to engage in dialogue. Facilitated dialogue groups were set up in a relatively neutral place the patient's tearoom off the ward in activities area. Groups were open in that people could come and go once engaged rather than being forced to stay or prevented from reengaging. This was important in the real worlds we were participating in. Nurses could be called away or may have to join a bit late and patients may have difficulty in concentrating for up to an hour, need a drink, smoke or toilet or whatever. No one was excluded from discussions; any nurse or patients deemed fit to be in the activities area (usually everyone) was free to participate. The groups became the central focus for all of the consequent change.

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(2) As some people will already know group discussions are not as simple as that. Often in inpatient circles they can be controlled events, slightly paternalistic and can become quite negative. Imagine asking people to talk about their experiences of acute inpatient care and interactions with professionals? As with a lot of research there will or could be an outpouring of the usual (though real) negativity associated within inpatient care. And imagine the willingness of professionals to stay or engage in such a negative environment and share their experiences against this onslaught? We were looking to improve the cultural interactions not perpetuate one. So it was agreed to conduct the group discussions (indeed all interactions) within an Appreciative Inquiry (AI) framework. The inquiry process begins with an unconditional positive question or topic. Phase one *Discovery* appreciates what is about this question or topic, phase two *Dreams* about how things could be, phase three *Designs* or co- constructs what should happen to achieve the dream. Finally the *Destiny* phase looks at what has to happen for the dream to be sustainable, see Figure 1. The simple idea being that if people constantly look to discover and increase positive aspects of a situation, that this becomes the driving force rather than perpetuating a negative status quo. Eventually the argument is that the positive focus will begin to draw out entrenched negativity and either displacing it or overtake it as the dominant force in the environment.



**Figure1. Adapted 4-D model: Phases of Appreciative Inquiry**

Cooperrider et al (2003)

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A normal conversation might go like this (even if the question was asking what was good about interactions!)

*“they treat you like a child as if you were stupid or something”*

Facilitated through the AI framework it would go something like this:

*“ when you are treated like a person, you know adult to adult you can have a much more normal conversation and are happy to talk about your problems”*

Using this type of approach allowed people to move forward through cycles of conversation that identified what was good and how it could be improved upon further. Rather than focussing on the negative and remaining in an untherapeutic space.

(3) As the AI cycle indicates it is possible to dream about different ways to interact more positively. This in itself is not sufficient; it was necessary to have a medium by which this can actually occur. I mentioned dialogue groups as the medium for transformation. Of course dialogue takes different forms. A nurse talking to a patient or doctor carrying out a clinical interview is a dialogue. At a superficial or monological level this is dialogue, though will not necessarily affect what occurs in the relationship. Dialogue as understood and practiced in groups was:

*“where it is perceived as a joint action that joins people together in a temporary mutual world experience. Participants have to be willing to engage in this dialogue or a situation needs to be created where it can ensue” (Bakhtin 1981)*

Crucial to dialogue is the absence of subject-object relationships and instead participants entered dialogue as subject – subject. This enables the sharing or unveiling of participant’s worlds as opposed to the domination of one by the other. *Through this unveiling and critical reflection participant engage in an authentic practice or dialogical action co-creating and naming their new world (Freire 1996).*

In this type of dialogue each person expresses their understanding or perception on the meaning of experience or interaction and is listened to by the others who in turn are given expression. Participants then reflect on the whole picture and together try and create some meaning that makes sense to them all or at least can be mutually understood. The very act of putting each persons story into the equation in itself creates new meaning. Through this dialogue people are in a position to explore ways of embracing different perceptions or agreeing conjoint ones. Consensus is good but not necessary as long as a mutual understanding or ways to move towards this is agreed. So for example as a nurse I don’t have to abandon my belief (if that is the case) in the benefits of a psychiatric diagnosis, whilst still being able to comfortably respect that this is not useful or indeed relevant to a person who is hearing voices. What was as important as the ability of participants to explore different meanings and perceptions of distressing experiences and how to be able to address, was the actual practice of engaging in this novel form of communication, alien to the institutional culture.

(4) The provision of a communicative space in the research where the above process could unfold, showed us how a sub cultural space could be made for meaningful interaction

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despite the oppressive culture associated with institutional routine. And we are presently working on ways of creating these opportunities in normal practice so that the affect can be sustained.

- (5) The inquiry took place over a year with most of the positive story unfolding over a six month period. I have chosen a few examples that give an indication of how we developed intracultural meaning and reached mutual understandings. (a) Primarily in achieving the aims of the research we were able to agree on where, when and how therapeutic interactions occur and consequently separate out this space from our other less favourable, though often necessary roles and interactions. We could not have achieved this without co-participation (nurses think one way and patients think another!), An approach (which allowed us to transcend an otherwise negative and untherapeutic process), dialogue (to explore what therapeutic intervention meant and could be!) and the creation of the communicative space (which provides our example of how to enshrine the process in normal practice). (b) One patient participant was very articulate and helped us unpack some of the difficulties in power relations that prevent therapeutic interactions. Several nurses were quite amazed at this level of interaction and understanding, one commenting later that normally this patient is unresponsive, monosyllabic and difficult to engage in any interaction. This helped them realise that when people can engage in equitable communication with respect for their perceptions and experience, they will actively engage with 'life'. As opposed to alternative 'institutional' forms of communication which clearly in this case not worthy of engaging with. (c) Patients saying that nurses do not engage with them on admission because they are a bit paranoid (in the colloquial and clinical sense) of everything which detract from the possibility of a therapeutic relationship. Nurses perception being that they realised patients are paranoid/suspicious so wanted to give them space to be less so, particularly as their acculturation process discouraged active engagement with this form of distress. Conjoint realisation that that paranoid suspicious feelings are more likely to be reduced if nurses honestly engage with patients in this state provided a new understanding and the potential for more early therapeutic interaction in the future. (d) When agreeing to differ was as good as it gets, e.g. nurses could only understand a persons belief that dark forces were after him as a delusion. Participants looked at new ways where patients and nurses could practice reconciling diverse stances and finding middle ways without dismissing each other's perspectives. In one example we talked about using less threatening discussion groups for debating differences, e.g. political opinion or stances on the environment. It was envisaged that skills learnt in this way would enable patients and nurses to be able to work meaningfully with each other regardless of alternative perspectives, the importance being that one perspective was not given dominance over another.

We discovered a way of crossing the cultural divide where we could mutually develop a way forward in relation to therapeutic interaction. It is not instead of everything else that goes on, nor is it extra. It is a place where we can do it differently, whilst trying to reconcile our roles in the quagmire that is acute inpatient care.