A social constructionist analysis of talk in episodes of psychiatric student nurse-psychiatric client community clinic based interaction

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Abstract

The study seeks to explore and to offer a critical account for the 'discursive doings' of student psychiatric nursing practice as they are jointly constructed in the episodes of conversation between the nurse and client-speakers within the context of the community-based psychiatric clinic. The study is built around a social constructionist framework and is concerned with the analysis of the discursive activities present within seven (7) transcribed, audio-recordings of student nurse-psychiatric client interactions. A thick and sometimes critical description of three of the contextual forces back grounding/foregrounding the discursive processes of psychiatric nursing is given. These include the public health psychiatric care context, the problem-solving approach of the undergraduate psychiatric nursing curriculum and the assumption and effects of modern psychiatric nursing theory.

The first level of analysis is an aspect of the methodology and offers a descriptive and interpretive analysis of the talk in the texts. Various conversational discourse analytic tools were used here to transform talk into text and to develop the starting point for the subsequent positioning theory analysis. The second level of analysis is a positioning theory analysis of happenings within these texts. Some of the textual descriptions generated in the first level of analysis are used to illuminate and to add substance to the accounts of these positioning theory happenings. The analysis has shown that from a social constructionist positioning perspective, the unfolding nurse-client dialogue in these texts operates in four potentially distinct ways - highlighting, herding, hectoring and heeding - with specific effects for their going on together in conditions of relationship.

These ways of talking are shown to be contrary to the person-centered rhetoric of modern psychiatric nursing and more aligned with the bio-medical format of talk in helping contexts. Can these activities be dismissed as non-nursing activities? The implications for a modern psychiatric nursing theory that holds the person-centred approach to be its quintessential essence are considered and a number of ideas for how client-authorised expressions may be jointly manifest in conversations situated in this practice context are offered.

Declaration

I declare that this thesis is my own original work. All sources of reference have been acknowledged. This work has not been submitted by me for any other degree at this, or any other university or institution.

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[1] Their contributions to this work are outlined in section 3.7.2 "Conclusion and the natural history of my research".

Contents

Preface

Abstract i
Declaration ii
Acknowledgements iii
Contents iv

Chapter One: The idea of this study 1

1.1 Introduction 1
Excerpt 1 1
1.2 Overall research purpose and process 4
1.3 Research focus 6
1.4 The two levels of analysis in this study 7
1.5 The contexts back grounding the study focus 7
1.6 Boundaries of this study 7
1.7 Conclusion: Map of the study 9

Chapter 2: The moral contexts 11

2.1 Introduction 11

2.2 The public health care context 11
2.2.1 The diagnostic-psychiatric moral order of speaking 15
Excerpt 2 18
2.2.2 The psychiatric clinic interview 18
Excerpt 3 21
2.2.3 Conclusion 24

2.3 The undergraduate psychiatric nursing context 24
2.3.1 Conclusion 28

2.4 The modern idea (s) of psychiatric nursing 29
2.4.1 The centrality of the person-centred doings of psychiatric nursing praxis 31
2.4.1.1 Conclusion 36
2.4.2 The invisibility of the rhetorical doings of psychiatric nursing in practice 37

2.4.2.1 Conclusion 44
2.4.3 Modern social theory and its implications for the visibility and invisibility of person-centred doings in practice 45
2.4.3.1 Implications for the doings of psychiatric nursing 46
2.4.3.1.1 Conclusion 52
2.4.4 Other knowledges for psychiatric nursing practice 53
2.4.4.1 Conclusions to other knowledges 56

2.5 Concluding remarks 57

Chapter 3: Methodology 58

3.1 Introduction 58

3.2 The research focus and route map 59

3.3 Social constructionist assumptions of the study 61
3.3.1 A constitutive view of language 62
3.3.2 Discourse and language 63
3.3.3 Social and psychological phenomena are constructed in language and discourse 65
3.3.4 Interpersonal meanings are generated in language in conditions of relationship 66
3.3.5 Patterns of social practice are generated and re-generated in dialogue 67
3.3.6 The self is a multiplicity of selves constructed and positioned in dialogue 68
3.3.6.1 Selfhood constructed in dialogue 69
3.3.6.2 Subject positions constructed in dialogue 70
3.3.6.3 Agency and self-authorisation 71
3.3.6.4 Conclusion 73
3.3.7 Social constructionism and social power 74
3.3.7.1 A constitutive view of knowledge/power and its effects 74
3.3.7.2 Techniques of disciplinary power/knowledge practices 75
3.3.7.2.1 Hierarchical observation 76
3.3.7.2.2 Normalizing judgement 77
3.3.7.2.3 The examination and the confessional 78
The examination 78
The confessional 79
3.3.7.3 Social power and transformation 79
3.3.7.4 A brief dialogue with the potential limits of post-structural power for social constructionist theorising 80
3.3.8 Conclusion to the theoretical assumptions of the study 81

3.4 The methodologies of analysis 81
3.4.1 Discourse analysis 82
3.4.2 Discourse analysis as a field of possibilities for a social constructionist inquiry 84
3.4.3 Positioning theory as one possibility in the field of discourse analysis possibilities 85
3.4.3.1 Introduction 85
3.4.3.2 The positioning triangle 86
3.4.3.3 Positioning practices 87
3.4.3.3.1 Unintentional first order positioning practices 88
3.4.3.3.2 Intentional second and third order positioning practices 88
Deliberate self-positioning 89
Forced self-positioning 90
Deliberate and force other positioning 90
3.4.3.4 The positioning triangle emphasis in this study 91
3.4.4 A reflexive account of a (my) methodological problem with positioning theory and its link with Fairclough's (1992) text structure analytic elements 92
3.4.5 Overview of Fairclough's (1992) three-dimensional theory of discourse 94
3.4.5.1 Text structure analytic elements 94
3.4.5.1.1 Exchange structures and turn-taking 95
3.4.5.1.2 Topic control 95
3.4.5.1.3 Setting and policing agendas 95
3.4.5.1.4 Formulations 96
3.4.6 Building a reflexive bridge between Fairclough's text structure elements and the process of this analysis 97
3.4.7 Conclusion 98

3.5 The 4 non-steps of the unfolding discourse analytic methodology for this study: Level one analysis 99
3.5.1 Generating texts 99
3.5.1.1 Selecting (purposive sampling) instance of talk for text 100
3.5.1.2 Introducing the text-speakers to the study 101
Table 1: Data about the speakers and the episodes of interaction 100
3.5.1.3 Transforming speaker-talk into text 102
3.5.1.3.1 Silverman's notations (1997, 2001) 103
Illustration 1 Silvermans' (1997 and 2001) notations 103
3.5.1.3.2 Mishler's notations (1984) 104
Illustration 2 Mishler's (1984) notations 104
Illustration 3 Mishler's and Silverman's adapted notations 105
3.5.2 Routes of entry into the texts: reading for awareness 106
3.5.2.1 The lenses of Fairclough and Foucault as a route of entry into the texts 106

3.5.2.1.1 An agenda for diagnostic psychiatry 107
Table 2: Summary of exchange sequences 108
Table 3: (Is at the end of the chapter)
Table 4: Summary of types of exchange sequences 110
Excerpt 4: Agenda for diagnostic psychiatry 111
3.5.2.1.2 Last minute additions to the agenda: Person-focus 112
3.5.2.1.3 Concluding comments 114
3.5.3 The agenda for a positioning theory analysis 114

3.6 Methodological goodness and completeness 114
3.6.1 How rigorous is this study? 117
3.6.1.1 Triangulation state of mind as offering depth 118
3.6.1.2 Consistency as offering goodness 118
3.6.1.3 Triangulation state of mind and consistency as offering some transferability between sites 120

3.7 Ethical considerations 120
3.7.1 Generating ethical texts 120
3.7.1. Obtaining ethical approval for the study 122
3.7.2 Conclusion as the natural history of my research 122
Table 3: Summary of topics of talk, the order in which they were raised in talk and the number of exchange sequences associated with each topic 125

Chapter 4: Analysis and discussion 126

4.1 Introduction 126

4.2 The retrospective gaze of the positioning theory analysis 127

4.3 First and second order positioning practices in student psychiatric nurse-client talk 128
4.3.1 Introduction 128
4.3.2 The first order positioning practice of Highlighting defined 128
4.3.3 The second order positioning practices of Herding, Hectoring and Heeding defined 129
4.3.4 The location of these practices in the texts 131
Table 5: Presence and location of the discursive positioning practices within the conversational sequence of each text 131
4.3.5 The discursive end-point of the doings of student psychiatric nurse-client talk in these texts 132

4.4 Textual analysis of first order positioning practices in student psychiatric nurse-client talk 133
4.4.1 The social action and positioning practices of highlighting 133
4.4.1.1 Social action of inquiring/reporting in highlighting 134
Excerpt 5 135
Excerpt 6 135
Excerpt 7 135
Excerpt 8 136
Excerpt 9 136
Excerpt 10 136
Excerpt 11 136
Excerpt 12 139
4.4.1.2 Social action of psychiatric inquiry/psychiatric accounting 141
Excerpt 13 143
4.4.1.3 Social action of life world inquiring/psychiatric accounting 145
Excerpt 14 146
4.4.1.4 Social actions of routine closing 148
Excerpt 15 148
Excerpt 16 149
Excerpt 17 149
Excerpt 18 149
Excerpt 19 149
Excerpt 20 150
Excerpt 21 150
4.4.1.5 Positioning in highlighting 151

4.5 Textual analysis of second order positioning practices in student psychiatric nurse-client talk 153
4.5.1 Introduction 153
Table 6: Location of herding and hectoring within the texts 154
4.5.2 The social actions and positioning practices of herding and hectoring illuminated 155
4.5.2.1 Herding: Social actions and positions illuminated 156
4.5.2.1.1 The social action of persuading/deferring distress in the direction of normative well-being 156
Excerpt 22 157
4.5.2.1.1.1 Positioning practices highlighted 159
4.5.2.1.2 The social action of persuading/deferring doubts about medication in the direction of the to-be-expected storyline 159
Excerpt 23 160
4.5.2.1.2.1 Positioning practices highlighted 162
4.5.2.1.3 The social action of persuading/deferring expressions of

distress as inconsequential to the to-be-expected psychiatric storyline 163
Excerpt 24 166
Excerpt 25 166
4.5.2.1.3.1 Positioning practices highlighted 166

4.5.2.2 Hectoring: Social action and positioning practices illuminated 167
4.5.2.2.1 The social action of compelling/surrendering well-being as a normative effect of medication 167
Excerpt 26 168
4.5.2.2.1.1 Positioning practices highlighted 171
4.5.2.2.2 The social action of compelling/surrendering expressions of agency as effects of the therapeutic properties of the Psychiatric moral order of speaking 172
Excerpt 27 174
4.5.2.2.3 The social action of compelling/surrendering life-world Distress in the direction of instrumental problem-solving 176
Excerpt 28 178
4.5.2.2.3.1 Positioning practices highlighted 179

4.6 The (in) visibility of heeding in these texts 179
4.6.1 Instances of client-centred talk in texts 182
Excerpt 29 182
4.6.2 Another instance of client-centred talk 184
Excerpt 30 185
4.6.3 Positioning practices highlighted 186

4.7 Summary and conclusion 186

Chapter 5: Concluding thoughts 190

5.1 Introduction 190
5.2 Interaction is a site of knowledge/power 191
5.3 Social constructionist possibilities for developing person-centered sites of knowledge/power for psychiatric nursing 193

5.3.1 Storyline 1: Relationships are sites of knowledge/power transformation 194
5.3.2 Storyline 2: Surfacing the disabling effects of our own rhetoric 196
5.3.3 Storyline 3: Evolving client and nurse-agency meanings in psychiatric nursing 198

5.4 Conclusion 201

Appendices **203**

Appendix A Transcript 1 203
Appendix B Transcript 2 205
Appendix C Transcript 3 208
Appendix D Transcript 4 211
Appendix E Transcript 5 212
Appendix F Transcript 6 220
Appendix G Transcript 7 227

Appendix H Ethical approval for the study 233

References **234-263**

Chapter One

The Idea of This Study

1.1 Introduction

The idea for this study has emerged out of the loose weaving together of my own observations of the undergraduate student psychiatric nurse-psychiatric client interactions at the local community psychiatric clinic, and the students' experiences of these interactions.

On the one hand and in the student psychiatric nurse-psychiatric client episodes of interaction [1] it seems that some kind of tacit understanding about what should be said and how it should be said is being jointly developed. That the student nurse's questions and the client's responses overlap and run into each other does not seem to bother either, or trouble the rhythm of the interaction.

Excerpt 1: The idea for the study

Nurse:	Okay any issue of concern that concerns you [Client: No] No? Nothing? [Client: nothing] Okay, are you still doing well with your medication [Client: Yes.] You sleeping well? [Client: Yes] eating well? [Client: yes] Okay how is your husband now?

1 Episodes can be defined as "...any sequence of happenings in which human beings engage which has some principle of unity." (Harre and van Langenhove, p.4, 1999.)

On the other hand, and in the praxis debriefing contexts[2] students tend to characterise these same episodes of interaction as predictable for the clinic context but antithetical to their understanding of the person-centred focus of modern psychiatric nursing. Students frequently report feeling distressed by this disconnection between understanding the interpersonal expectations of psychiatric nursing theory and the question-answer, psychiatric focus of the clinic context.

Difficulty in practising from a person-oriented perspective in this clinic context is generally framed as a personal deficit for which they feel acutely responsible and sometimes, ashamed (Austin, Bergrum and Goldberg 2003; Lutzen, Dahlqvist, Eriksson and Norberg, 2006; Pask, 2003). Anecdotal comments such as the following are common-place. "I should have done it better; I can't seem to help this client; I know I was going in the wrong direction but I just couldn't seem to stop it but I suppose it is okay because the sister asked me to be quicker because of the long queue; I am not meant to be a psychiatric nurse".

The modern understanding of psychiatric nursing is that it is a person-oriented, interpersonal process directed towards the mental health needs of people[3] Austin, Bergrum and Goldberg (2003) suggest that the interpersonal process is the site at which psychiatric nursing practice is made visible as a distinct discipline in health care. This interaction is seen as a private conversational space wherein sustained expressions of the client's health needs, health experiences and his/her understanding of them, are facilitated by the nurse (Peplau, 1952). The term 'person-centered approach' is thus used to define the action orientation of psychiatric nursing – the conversational doings - in both theory and practice (Crowe, 2000; Forchuk and Reynolds, 2001; Uys, 2004 [4]).

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[2] The term praxis de-briefing is used here to describe discussion classes where the process, content and outcome of specific clinical experiences are explored for their grounding in theoretical ideas about psychiatric nursing (Sandelowski, 1997; Tarlier, 2005).

[3] See Chapter 2, section 2.4 for a fuller account of the evolutions of this understanding.

The visibility of this approach in clinical interactions is therefore regarded as both the aim and the measure of psychiatric nursing practice. Practice which does not manifest or at least establish in some way that it is working towards this end-point, is regarded at the very least, as problematic because of its opposing stance to the person-centred focus of the action-orientation of psychiatric nursing theory and practice (Forchuk and Reynolds, 2001; Uys, 2004 [4]).

I have noticed that the person-centred approach usually sits at the margins of the psychiatric student nurse/client clinic-based interaction and that it is the diagnostic-psychiatry focus of the public health psychiatric services that occupies centre-stage (Horwitz, 2002). Even though the desire to engage with the life world of another is often cited by students as the primary reason for their interest in psychiatric nursing, it seems that this desire is often held in suspense while the `real work' of the formal interview - namely gathering information about symptoms, medication effects and compliance and normative expressions of social and occupational functioning - is accomplished. In many instances, person-centred talk - defined colloquially here as taking time to talk with the person about their lived-experiences - takes place outside of the formal interview, in the corridor, the waiting room or even the lift.

We (the students and I) frequently speculate about what happens in these clinic-based student nurse-client interactions to make it difficult for students to realise their understanding of the classic expectations of person-centred psychiatric nursing. In the main, students cite having insufficient time for in-depth conversations because of the long queues, because of clients being impatient about wanting to collect their medication and leave and because the clients know what to say in the interview and sometimes answer the questions before they are asked.

These then, are some of the informal observations which have contributed to the development of the guiding research question for this study and the decision to

use a qualitative, social constructionist methodology (Morse, 2006 [1]; Willig, 2001). This guiding query is embedded within what I understand to be a disconnection between how psychiatric nursing defines itself as a person-centred practice in theory and the discursive doing of this understanding in student psychiatric nurse psychiatric clinic-based practice.

1.2 Overall Research Purpose and Process

This study seeks to explore and to critically account for the 'discursive doings' of student psychiatric nursing practice as they are jointly constructed in the episodes of conversation between the nurse and client-speakers within the context of the community-based psychiatric clinic. Further, it seeks to develop a number of recommendations or ideas for how client-centred expressions of student psychiatric nurse practice may be jointly manifest in conversations situated in this practice context.

The primary intention of this study is to move the exploration of what it is that student psychiatric nurses and clients do in clinic-based conversation out of the realm of the "either client or nurse" reported experience and into the realm of discursive practice, that is, into the domain of language as instance of social practice in specific contexts (Austin, Bergrum and Goldberg, 2003; Harre and van Langenhove, 1999; Paley, 2001; Titscher, Meyer, Wodak and Vetter, 2000).

To this end, the terms "moral order of speaking" and "moral context" will be used throughout the study to refer to the discursive contexts within which these texts are situated and produced, such as for example, the psychiatric clinic[4]. More specifically, the terms are used in positioning theory to describe the linguistic practices through which each type of context maintains and regulates its moral

4 These contexts are described in detail in Chapter 2.

boundaries, that is, social relations between people, between persons and things (e.g. property) and between groups of people (such as social and professional hierarchies) and through which social norms for character, persona, behaviour and physical appearance are promulgated (Harre & van Langenhove, 1999; Moghaddam, 1999.)

The idea that it is possible to know, even partly, the essence of a particular reality and to use this knowledge as a normative measure for its presence and action in other contexts, most commonly underpins contemporary psychiatric nursing knowledge generating activities (Irving, Treacy, Scott, Hyde, Butler and MacNeela, 2006; Thorne, Canam, Dahinten, Hall, Henderson and Kirkham, 1998; Tarlier, 2005). It is hoped that this epistemological move from reported experience to language as the site and source of meaning will yield different insights about what it is that is accomplished in episodes of student-client talk, how they do it, and with what effects for the nurse-client interaction situated in the clinic context (Harre and van Langenhove, 1999).

Following Silverman (2001) and Willig (2001), a process-oriented, open-ended research query rather than a distinct set of research aims and objectives guide the intention of this study. Willig (2001) suggests that the covertly positivist trend in some qualitative research of delineating a distinct set of aims and objectives may inadvertently undermine the process-oriented, meaning-generating nature of 'big question' (big Q) qualitative research. This study is situated within the big Q meaning of qualitative research and is built around a social constructionist framework.

This study is concerned with the analysis of the discursive activities present within seven (7) transcribed, audio-recordings of student nurse-psychiatric client interactions (hereafter, referred to as the texts) recorded at a psychiatric community-based clinic over two years. To these ends, an inclusive discourse

analytic approach which draws upon elements of discourse analysis and positioning theory is used to provide a thick description of the contexts within which the research question is embedded, the methodology, the analysis and subsequent theorising about the attributes of effective student psychiatric nursing practice (Holliday, 2002).

1.3 Research focus

Specifically, the study hopes to offer detailed and where possible, explanatory answers to the following guiding questions:

1.3.1 How are the 'doings' or social actions of student psychiatric nurse-client talk discursively constructed and accomplished within these episodes of interaction between the student psychiatric nurses and the clients at the community-based psychiatric clinic?

1.3.2 How are the nurse and client positioned in relation to each other within and by these discursive doings and with what effects for the evolving interaction?

1.3.3 How does the moral order of speaking (discursive contexts) within which these texts are located and these discursive doings, constitute each other and with what effects for other ways of doing?

1.3.4 How can the principles of social constructionism, its analytic devices and the findings of this study be used to develop ideas for how client-centred expressions of practice may be jointly manifest in conversation situated in different contexts?

1.4 The two levels of analysis in this study

This study has two levels of analysis. The first is an aspect of the methodology and offers a descriptive and interpretive analysis of the talk in the texts and can be found in chapter three (Mishler, 1984). Various conversational discourse analytic tools were used here to transform talk into text and to develop the starting point for the subsequent positioning theory analysis. Numbers are used to illustrate the presence and frequency of certain kinds and topics of talk in these texts (Berman, Ford-Gilboe and Campbell, 1998). The second level of analysis is a positioning theory analysis of what might be happening within these texts and this is the substance of chapter four. Some of the textual descriptions generated in the first level of analysis are used to illuminate and to add substance to the accounts of these happenings.

The reasons these two levels of analysis are situated in different positions in this study are provided in section 3.4.4 "A reflexive account of a (my) methodological problem with positioning theory and its link with Fairclough's (1992) text structure analytic elements".

1.5 The contexts back grounding the study focus

This study is concerned specifically with how the activities of psychiatric nursing are discursively constructed in the texts. I noted in section 1.3 that these activities are constructed in conversation between the student psychiatric nurse and client within the psychiatric moral order of the clinic. Their conversation contains fragments of this and other moral contexts, notably the person-centered approach of psychiatric nursing and the problem-based approach of the undergraduate curriculum. The decision to focus on these and not any other contexts is derived from the observed dissonance between how psychiatric nursing defines itself as a person-centred practice in theory and the discursive doing of this understanding in these

student psychiatric nurse psychiatric clinic-based texts.

1.6 Boundaries of this study

This section outlines three potential boundaries for this study. The first boundary may be the theoretical decision I have taken to limit the analytic focus of the study to the discursive actions of the texts, i.e., to the social actions accomplished within the texts. The study is therefore concerned with exploring how the discursive activities of psychiatric nursing are constructed within the texts and not with a detailed analysis of the wider social practices of the moral orders within which they are located. While this study does make forays into the discourses of the wider moral contexts, it does so only in as much as these forays add substance to the interpersonal positioning theory focus of the analysis. This is entirely consistent with the assumptions of social constructionism which regards conversation and conversation-like activities (texts, their social effects or actions and their wider social context) as both the substance of social reality and the resource for its study.

The second boundary is related to the first. It might be very worthwhile to explore in a similar way, how the activities of psychiatric nursing are discursively constructed in other interpersonal contexts such as in episodes of experienced psychiatric nurse-client interactions and in student-teacher interaction in the praxis debriefing contexts. This might highlight the different doings of psychiatric nursing in different contexts and open avenues for dialogue between the different and competing constructions of the activities of psychiatric nursing practice.

The third boundary is the extent to which issues of gender, culture and race are not addressed in this study. This decision is discussed further in chapter three as an aspect of the methodology. Gender, culture and race are regarded as concepts constructed in reality rather than as a-priori facets of a particular social reality and which need to be controlled for in the study (Willig, 2001). If this study were for

example, about how nurses as women interact with clients, then the subsequent analysis would be built around different understandings of gender.

Finally, this study is not about the theory or practice of nursing education as a discipline. It is not about teaching in the class or clinic context. It is also not directly concerned with explicating the merits or de-merits of one way of learning, over another. It is not about models for reflective thinking or problem-based learning. It is also not concerned directly with curriculum development. It is however possible that many of these influences, ideas or concepts may reveal themselves in a critical analysis of the texts in subsequent chapters. This study is primarily a study of the discursive doings of student nurse-psychiatric client talk situated in a specific context and conceptualised as a socially constructed effect of and resource for these (and many) forces.

1.7 Conclusion: Map of the study

The context within which this study's query is situated has been set and its boundaries established. This section outlines the theoretical and methodological research-process-as-adventure route that the study follows.

Chapter two provides a more detailed account of three of the moral orders of speaking back grounding the study's research query, intent, methodologies and analysis. These are the moral orders of the psychiatric clinic, of the curriculum-as-praxis approach of the undergraduate nursing curriculum and of the person-centered approach of modern psychiatric nursing. These contexts are explained and where necessary, connections between them are drawn.

Chapter three details the principles of social constructionism and its' discourse analytic devices. An account of the synthetic discourse analytic approach used in this study, namely positioning theory, is given. This is followed by a detailed account of how some of Fairclough's (1992) text analysis tools were used to identify

the storyline of "psychiatric surveillance" thought to be at work within these texts and which is then taken as the starting point for the positioning analysis in chapter four. (Fairclough, 1992; Titscher, Meyer, Wodak and Vetter, 2000).

Chapter four illuminates the discursive doings of student psychiatric nurse-client talk identified in the texts and outlines their potential effects for the nurse and client working together in conditions of relationship. To this end, some post-structuralist ideas about disciplinary power are used to explore how these doings work to manifest and/or disable ways of talking, including the client-centred approach, within the psychiatric surveillance storyline.

Chapter five concludes the study by considering the various ways in which the outcomes of the analysis and the assumptions of social constructionism might be used to develop a series of ideas for evolving nurse-client expressions of client-centred talk situated within the moral order of the community-based psychiatric clinic.

Chapter Two

The Moral Contexts

2.1 Introduction

This chapter describes three of the moral contexts – the psychiatric clinic, the theoretical premises of the psychiatric nursing person-focussed approach and the undergraduate problem-based curriculum – within which these texts or the objects of analysis were generated and are situated. Some of the potential tensions visible within in each context are highlighted. The idea of embedding the research focus in a rich description of its moral contexts is an aspect of social constructionist inquiry and specifically, of methodological rigour in constructionist research [1](Holliday, 2002). However, embedding is necessarily a discursive activity that carries with it the researcher's interpretations of what constitutes contexts and their possible tensions (Willig, 2001).

2.2 The public health care context

The South African public health sector is organized around the principles of a comprehensive, primary health care approach (PHC) to health service delivery (Uys 2004[1]). This approach as it is reflected in the South African National Health Policy of 1994 is based on the values of a dynamic and comprehensive understanding of health, on justice, community accessibility, affordability, consumer empowerment and on a district health delivery system (Health Systems Trust, 2002). The district

[1] See Chapter Three, section 3.6 methodological rigour and goodness.

health system makes basic, comprehensive primary care accessible at local community sites and specialized care available at regional hospitals and tertiary specialist institutions (Petersen, 1999; Uys, 2004[2]).

The PHC approach has or hopes to achieve, a three-fold shift in the site, structure and public perception of mental health care service delivery and systems. The site of care has shifted from the psychiatric hospital and specifically designated psychiatric clinics to community based comprehensive primary health care settings (Uys, 2004[2]). Although the process of psychiatric deinstitutionalization and community-based care preceded the 1994 change in health care policy, mental health care services were vertically arranged within the discipline of psychiatry and therefore isolated from the lateral arrangements of the physical health care services (Health Systems Trust, 2002).

Most accounts of the history of psychiatric care in the public sector in general and of South Africa in particular, reflect the peripheralisation of people diagnosed with mental illness and the illness itself, from the central health care system (Hall, 1999; Thornicroft and Tansella, 2004; Uys, 2004 [2]). Originally the domain of the prison service, psychiatric care has made the transition from the social welfare department to a centrally controlled system outside of the provincial departments of health, to the provincial departments of health in the early 1980's and finally, to the (margins of the) comprehensive PHC system (Uys, 2004 [3]). This marginalization is captured in the frequently used word "Cinderella" to describe the unequal relations between marginalized psychiatric care and emphasized general care in the health care system (Hall, 1999; Sayce, 2000; Szasz, 1991).

A corollary of service marginalization is the stigmatization of people consuming the service as different, inferior, set apart and powerless (Hall, 1999; Szasz, 1991). Hopton (1997) argues that mentally distressed people are explicitly located on the downside of social, economic and political relations. The social and

economic profile of psychiatric clients attending public health care clinics developed by Uys (1994; 1997) and Makhale and Uys, (1997), succinctly illustrates this point. This profile suggests that most psychiatric clients are diagnosed with a psychiatric illness during the economically productive ages of 15-35; are unemployed and economically dependent on others or on state grants; and support a number of family members on their grant. It is envisioned that an integrated, comprehensive health service will go some way towards reducing the stigma of mental illness and to developing a culture of inclusion, at least at the sites of community life and health care delivery (Uys, 2004 [2]).

The 2003/2004 annual report of the Department of Health reports that to date, about 80% of the health care districts have started the process of integrating mental health care into primary health care services, and about 40% have achieved integration (Department of Health, 2004 [2]). Further, the Department of Health's quarterly review of activities for the period June to September 2004 shows that 50% of clinics and 70% of hospitals across all health care districts are integrated and offer a mental health service. Both these reports suggest that the slow and sometimes uneven speed with which integration has occurred has been influenced by a number of factors, including the limited infrastructure of many clinics where physical space is a scarce commodity. While the quarterly report suggests that the primary reasons for non-achievement are "shortage of specialists, shortage of skills, and shortage of dedicated services" (p 62) it is not explicit about these shortages and it does not explain how they are manifest as shortages in the process of integration. Nevertheless, the need to "improve mental health services" is listed as a key activity for achieving the strategic priority of "improving the management of communicable and non-communicable diseases" for the period 2004-2009 (Department of Health, 2004 [1]).

Whether integration will successfully manifest psychiatric care as an important and obvious aspect of a comprehensive service remains to be seen and to

be researched. There are many anecdotal reports that point in both directions. On the one hand, positive reports exist where psychiatric services have become available where previously there were none, particularly in the more rural areas of the country[2]. Having a single consultation rather than a fragmented "body-part" experience of health care might also reduce the financial and time costs associated with multiple visits for different body-parts, for clients. On the other hand, some of the mental health professionals involved in the process of integration report a range of unsettling experiences that have caused them to question the extent to which integration will benefit their clients and the specialist discipline of psychiatric nursing[3]. For example, some specialist psychiatric clinics report moving to integrated premises only to find that the space allocated in planning meetings has been reduced, leaving them with a single room to serve as a waiting room, an interviewing room, a space for office work and a clinical treatment room. Another example is the extent to which psychiatric clients (including those who are medication and symptom-stable) are publicly separated out from the general health clients at primary health care clinics, and in so separating, are distinctly marked as different.

Although the PHC approach calls for a comprehensive, lifestyle management perspective of health and health care, its services are currently organized around the medical model (Petersen, 1999). This is highlighted in the previous paragraph where the need to "improve mental health services" is listed as a key activity for achieving the strategic priority of "improving the management of communicable and non-communicable diseases" (Department of Health, 2004 [1]). This model emphasizes health as the absence of disease, and treatment as the processes of disease identification and cure though pharmacological and/or surgical procedures

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[2]Tele-conference of the 23rd February 2005, 22nd February 2005 between five community-based psychiatric nurse practitioners from four different provinces in the country, and myself.

[3] Refers to the tele-conference above and to on-going conversations between me and the community psychiatric nursing staff of two clinics in the Durban area.

(Thornicroft and Tansella, 2004; Pratt, Gill, Barrett and Roberts, 1999). While assessment and pharmacological interventions are important aspects of mental health care, studies have amply demonstrated the efficacy of psychosocial rehabilitation in the reduction of burden (personal, family, organisation, community, health system resource use) (Dornbos, 2001; Pratt, Gill, Barrett and Roberts, 1999).

Rehabilitation is most often conceptualised as a physical activity. For example, the rehabilitation programme summary in the Department of Health's quarterly report (July 2004 to 30 September 2004) talks only of physical disabilities and makes no mention of mental health rehabilitation activities (Department of Health, 2004 [2]). Furthermore, where mental health rehabilitation activities could possibly be inferred in the objective "to promote the human rights and social integration of people with disabilities", there are no activities listed for this objective and "no budget" is cited as the reason for its non-accomplishment. There is also, as far as I can see, no mention of rehabilitation in the strategic planning for 2004-2009, document (Department of Health, 2004 [1]). The idea of integration is a complex one and speaks not only to the physical integration of services, but also to the extent to which particular services, service providers and consumers recognise themselves and are recognised as visible elements of a comprehensive health care approach.

2.2.1 The diagnostic-psychiatric moral order of speaking

Community clinic-based care predominates in the South African public mental health sector with a small minority of psychiatric clients (25%) being cared for on an in-patient basis (Uys, 2004 [1]). Psychiatric care within both of these settings is organised around the bio-medical model of treatment (Petersen, 1999). More recently, psychiatric care has been defined as diagnostic psychiatric care with its emphasis on the process of diagnosis as a pre-requisite to pharmacological and other forms of treatment (Horwitz, 2002). Although decisions about pharmacological

intervention are generally based on presenting psychiatric signs and symptoms, medication prescribing is frequently used as a rationale for the authority of the diagnostic classification process in psychiatric care (Crowe, 2006; Horwitz, 2002).

The central premise of the diagnostic psychiatry approach as exemplified in the Diagnostic and Statistical Manual of Mental Disorders (third edition and onwards) is that mental illnesses are discrete, natural entities best identified and ameliorated by medical means, most notably psychiatric classification and pharmacological intervention (Casey and Long, 2003; Crowe, 2006; Hayne, 2003; Horwitz, 2002; Littlejohn, 2003; Montgomery and Webster, 1994). One of the many criticisms of this classificatory model is its theoretical turn-away from etiology towards an atheoretical, symptom based approach to categorization with the embedded implication of it being a "...way of grouping all of life" (Horwitz, 2002 p. 71). This system conceptualises both overt psychiatric symptoms and many of the problems of ordinary life as discrete forms of individual pathology and as normative measures of functional ability (Horwitz, 2002).

Hayne (2003) suggests that significant social power derives from this all-encompassing view of disease. Parker, Georgaca, Harper, Mclaughlin and Stowell-Smith (1995) suggest that professionals may construct psychopathology through the ways in which they draw on the language of diagnostic-psychiatry to conceptualise human behaviour as disorder in the first place. Casey and Long (2003) further this argument and suggest that the medicalisation of mental distress effectively legitimises and excludes those disciplinary practices that might disempower people, from scrutiny. For example, Hayne (2003) and others (Casey and Long, 2003; Crowe, 2006; Horwitz, 2002; Jonsdottir, Litchfield and Pharris, 2004) argue that many psychiatric clients experience diagnosis as stifling of their personal explanations of and rights to their own experiences of mental distress. These authors suggest that psychiatric diagnosis is a socially sanctioned way of understanding mental suffering and that its application in practice regulates how suffering is experienced and in so

regulating, achieves uniformity and social order.

This is not to suggest that the process of diagnosis is inherently problematic (Jonsdottir, Litchfield and Pharris 2004). Numerous studies over the past ten years suggest that many clients and family members feel empowered by the medical orientation of the diagnosis because it legitimises the illness and in so doing, reduces some of the social embarrassment associated with being different (Jonsdottir, Litchfield and Pharris 2004; Hayne, 2003; Murphy and Moller, 1993).

What is being challenged here is the extent to which psychiatric nursing care is being limited to uniform, medicalised expressions of care, corresponding to psychiatric-diagnostic treatment of disease processes that discount peoples' experiences of what it is to live and cope with a mental illness (Gergen, 1999; Jonsdottir, Litchfield and Pharris, 2004). Nevertheless, Hayne's (2003) study does suggest that while the client-respondents experienced some benefit of diagnosis, in the main they experienced the power differential created by medical language as undermining of their sense of person-hood and as a disadvantage to their progress towards a sustained sense of wellness.

The following excerpt from transcript 6 (below) illustrates how the clients personal description of tiredness is being constructed in the nurse's utterance - **Are you tired e:very morning or (.) every day?**- as a medical symptom and is being actively worked for its differential diagnostic potential while the life-world focus is excluded. This excerpt is briefly discussed here and presented over the page (please refer to Chapter 3 page 103 section 3.5.1.3.1: Silverman's (1997 and 2001) notations for an explanation of the transcribing devices).

Is the problem of tiredness a possible signal of an early relapse (in which case the person might feel tired most of the day), or is it a developing depression (which is experienced in this case as feeling unrefreshed and tired, even after sufficient sleep)? Although the client's utterances in this example show an orientation towards

a life-world focus (lines 4, 5 and 9), this focus is recruited into the all encompassing world view of disease - everything said and done is an indication of illness - **"Okay, you get tired"** (line 11). Its visibility as a potential impetus for a different kind of knowledge about the client to develop in this interaction is therefore reduced.

Excerpt 2: Medical talk/biographical talk (Transcript 6 Appendix F lines 1-13)

1	1.1	Q	Nurse: ((OIS))	***How are you*** ((today?)
2		A	Client:	I'm feeling ((coughs)) feeling okay.
3	1.2	PReq	Nurse: ((OIS))	You're feeling oka::y?
4		A	Client:	A bit tired (.) but (.) but that's:: my age (.) I'm
5				Getting older, you know ((laughs)).
6	1.3	PReq	Nurse: ((CIS))	Are you tired e:very morning or (.) every day?
7		A	Client:	Uh (.5) No (.) no:: I get (.) energy you know but
8				m (.) I'm almost 65 (.) at retirement age now so
9				((laughs)) I get tired (.) you know.
10				
11	2.1	PRaQ	Nurse: ((CIS))	(2sec) Mm:: Okay you get tired (.) ***do you come***
12				***here every month (1sec) for your medication***?=
13		A	Client:	=Yes.

2.2.2 The psychiatric clinic interview

The diagnostic psychiatry orientation predominates in psychiatric in-patient and outpatient services (Petersen, 1999; Uys, 2004 [1]) and this is manifest to a greater of lesser extent, in its institutional principles and practices. One example of such an institutional practice is the clinic-based nurse-client interview. This interview is regarded as the organising principle of community-clinic care and the medium through which the interpersonal process of psychiatric nursing is articulated in community practice.

The texts for this study were generated in a community-based psychiatric clinic. This particular clinic stands apart from a comprehensive care setting and historically, serves a wide urban population. Currently, its clients and staff are being

integrated into various PHC services and clinics situated within the local health district. The account of the clinic that follows is therefore an account of a psychiatric service which will very shortly no longer exist but which is nevertheless, ubiquitous in the South African public health sector.

The clinic is a resource for newly diagnosed and previously diagnosed and medication-stable psychiatric clients. Most of the clients attending the clinic are unemployed and have been for between five and twenty years; have a limited income or are dependant on some form of social grant; live with family members or in subsidised government and non-government shelters; and support other family members with their disability grant. The most commonly occurring diagnoses among this population are schizophrenia, followed by a mental illness with some form of substance abuse, followed by depression and anxiety (Middleton, 2001).

Health practitioners of the public and private health care sectors generally refer clients to the service. The clinic does offer a "walk-in service" for people in distress although this is not their main source of referral. Clients are first assessed by the nurse and then by a doctor, before necessary physical tests and/or psychotropic medications are prescribed. Thereafter, psychiatric clients are expected to attend the clinic once a month for an indefinite period. Each time they attend the clinic they are interviewed by a registered psychiatric nurse, or by a student psychiatric nurse working under the supervision of the registered nurse.

These regular monthly interviews are colloquially termed "routine medication interviews". The average duration of an interview has not been formally documented but anecdotal reports place their duration between one minute and twenty minutes, depending upon the degree of client distress and the time it takes to elicit the required information. Intake interviews usually take longer (twenty minutes to one hour) because of the amount of personal and illness history data needed for the process of diagnosis and treatment.

The structure, content and outcomes of both routine and intake nurse-client and client-doctor interviews are consistent with the basic premise of the psychiatric diagnostic model. In the former, the efficacy of prescribed psychotropic medication is evaluated in terms of the presence or absence of psychiatric symptoms and their impact on the persons' functional abilities (Horwitz, 2002; Makhale and Uys, 1997; Pietersen and Middleton, 2004; Uys, 1997). In the latter, the focus is upon establishing a psychiatric diagnosis and initiating treatment. Irrespective of the focus of the interview, the outcome usually falls into one or more of the following activities- organising admission to a hospital, referring the client to the social worker (if there is one) for disability grant assistance and re-issuing medication (Makhale and Uys, 1997; Uys, 1997).

The effects of the diagnostic psychiatric orientation are further evident in the ways in which participants in these texts engage with one another and with the topics under review. In the first place, the conceptualisation of mental illness as a bio-medical phenomenon immediately places the doctor and the nurse in the position of knowledgeable expert in relation to the client (Hayne, 2003; Latvala, Janhonen and Wahlberg, 1999). Secondly, interaction at this site is largely in the form of a "professional monologue" and usually consists of a series of closed-ended questions about the presence or absence of psychiatric symptoms, the efficacy of the medication in controlling symptoms and a broad-based surveillance of how the person is functioning in the activities of daily living such as managing family relationships, friendships, leisure time, financial resources and domestic living arrangements (Latvala, Janhonen and Wahlberg, 1999; Latvala, 2002; Pietersen and Middleton, 2004).

This phenomenon is exemplified in excerpt 3 over the page, given here in its entire brevity.

In this excerpt, a sense of person-hood is not immediately obvious in the

utterances of either speaker; a supervisory, surveilling and paternal (lines 16-19) overtone predominates (Breeze, 1998). The interaction is controlled by the nurse and is reduced to biological functions, well-being of a family member, efficacy of medication and a brief statement about the absence of problems being a direct outcome of the efficacy of medication. In keeping with the atmosphere of qualitative research, it is important to note that there may be a range of explanations for the "happenings" in this text, only one of which is the professional-driven nature of diagnostic psychiatry.

Excerpt 3: Professional monologues (Transcript 4 Appendix D lines 1-27)

1	1.1	Q	Nurse: (OIS))	Okay (.) *any issue of concern* that concerns you?
2		A	Client:	Nothing=
3	2.1	PRaQ	Nurse: ((CIS))	Okay (.5) are you still (.) doing well with your
4				**medication?**
5		A	Client:	Yes.
6				
7	3.1	Prq	Nurse: ((CIS)	**Sleeping well, eating well?**
8		A	Client:	Yes.
9				
10	4.1	PraQ	Nurse: ((OIS))	Okay (.) How is **your husband now?=**
11		A	Client:	=He's alright (.) alright.
12				
13	5.1	PraQ	Nurse: ((CIS))	Okay (.5) **then you came for your medication?=**
14		A	Client:	=Yes
15				
16	5.2	PRaID	Nurse: ((ID))	(3 sec) Okay (.5) you must (.) continue taking your
17				medication well (.) so that (.) it will help you (Clien
18				so you will no longer have any other
19				problems, oka::y?=
20		A	Client:	=Yes.
21				
22	6.1	PRaID	Nurse: ((ID))	=Okay, I'm going to check (.) your date for *your*
23				*Next visit*. It will be on 15th of next month (.) that
24				is April.((Client: Okay.) Okay thanks See you next
25				time. You can go and take your medication bye-
26				bye.
27		A	Client:	Thank you.

The structure, purpose, content and focus of the nurse-client interaction in the community-based psychiatric context are relatively stable over space and time. Standardized psychiatric procedures, such as the organization of the clinic, the

history-taking format and the essential psychiatric drug list (EDL) for the treatment of commonly occurring psychiatric conditions, help to maintain a stable and predictable service. This institutional routine makes it easier for newly transferred psychiatric nurses and clients to fit into. For example, 90% of the thirty psychiatric clinics used for psychiatric nursing training in KwaZulu-Natal and the Eastern Cape offer a daily psychiatric clinic with medication and symptom monitoring as the core therapeutic activities (Middleton, 2001).

Other forms of psychosocial intervention such as supportive counselling, health education and family support may occur (in sixteen of the clinics) but are incidental to the primary focus of the clinic interview. Most of these clinics are structured in a similar way with client interviews and hospital admissions in the mornings and meetings, client home visits (transport dependent) and clinic administration in the afternoons. The average number of patients attending clinics each day will vary and range from an average of six clients a day in a small rural clinic in the Eastern Cape, to one hundred to one hundred and fifty clients a day at a busy urban clinic in KwaZulu-Natal. (Middleton, 2001.)

The preceding description of the clinic does not account for the instrumental and social love many nurses show their clients (Li, 2004; Peternelj-Taylor, 2002; Stickley and Freshwater, 2002). Stickley and Freshwater (2002) describe how the art of love within nursing care might be developed through the combined activities of commitment, patience, concern and the on-going practice of sustained acts of loving. Although these authors do not explicitly define the concept 'love', they do explicitly exclude erotic and sexual love from their framework.

Almost all of the psychiatric nurses I have met over the past years speak of their psychiatric clients with warmth, sometimes with irritation but almost always with compassion, active and on-going involvement and interest in their lives. Activities such as giving money for bus fare, for milk, cigarettes, for basic food stuffs; using private vehicles for some home visits because they know if they do not, the

client will relapse with horrible consequences for the family; giving warm clothes for winter; interceding with family members/employers/social workers on behalf of their clients, are common-place. This kind of compassion and non-medicalised attention is not captured in these texts; they seem remarkably devoid of love, if love is conceptualised in the way of Stickley and Freshwater, (2002).

Conversations with clinic sisters and student nurses suggest that loving interactions occur outside of the "routine medication interview", in the corridors, the lift, and the smoking area. The function of these corridor conversations may parallel the function of what Hardey, Payne and Coleman (2000) refer to as the hidden scraps of hidden personal and professional nursing knowledge in their study of nursing care. Their study explored the construction and function of personalized recordings of information about clients (in this case, about clients in an acute elderly care unit) that are routinely made on any available piece of paper and kept in uniform pockets.

The study found that these scraps of knowledge were an invaluable source of knowledge about the dynamic process of on-going, personalized nursing care that was not reflected in the formal nursing records and hand-over procedures. The latter records tended to be dated and to be constructed around bio-medical categories that represented clients as "body-parts". Scraps on the other hand, were more likely to reflect "everything", from information about bodily states, things to do, things to remember to tell clients, to perceptions (both negative and positive) of clients and their nursing care needs. These authors suggest that while scraps allow nurses to move beyond the medicalised discourse of formal nursing records, they also have the effect of marginalizing the distinctive voice of nursing from formal exchanges and in so doing, of re-inscribing the dominance of the medical model.

It is therefore possible that an exploration of these corridor sites of interaction as potential "scraps of information" would yield a more diverse picture of what else it is that psychiatric nurses do in their interactions with clients. On the other hand, as

with the written scraps, these verbal scraps raise questions about how it is that these interpersonal activities, archetypically psychiatric nursing, are rendered invisible at formal sites of psychiatric nursing care. How is it that the activities of medical psychiatry, and from which psychiatric nursing has historically distanced itself, are given priority in this essentially psychiatric nursing space (Boling, 2003; Fischer, 1991; Hopton, 1997; Inam, 2001; Littlejohn, 2003; Wilkin, 2001)?

2.2.3 Conclusion

In this section (2.2), I have attempted to situate the psychiatric clinic within the broader health delivery context and in what I understand to be its moral order of speaking. I have suggested that the pronounced visibility of the medical model in both of these contexts may have implications for how mental health is conceptualised and its services integrated into PHC. I have also suggested that this same medical visibility has implications for the kind of knowledge about what psychiatric nursing is and does and about the nurse and the client, which develops at these sites. The following section (2.3) explores the nursing education context within which the nurses in the texts are situated and which influences the type of psychiatric nursing knowledge that manifests at this site. Section 2.4 explores the context of the field (s) of psychiatric nursing knowledge and uses the nurse-client relationship as its focal point.

2.3 The undergraduate psychiatric nursing programme context

One of the researcher's functions as an educator within the School of Nursing is to assist undergraduate nursing students in their 4th year of the comprehensive nursing degree programme to become conversant and comfortable with the body of

skill and knowledge associated with the practice of modern psychiatric nursing. The researcher's position of researcher and educator of the researched in this study is an aspect of reflexivity which is addressed in various ways, throughout the study. For the moment and speaking form the position of educator, a critical focus of psychiatric nursing teaching in the praxis context, is to assist students to realize the modern understanding of psychiatric nursing as a humanist, client-oriented and interpersonal process in their encounters with clients.

Within this framework, the interaction between the student nurse and the client (whether individual, group or community) is seen as the primary site of nursing knowledge development. Because community clinic-based care predominates in the public mental health sector, the nurse-client interaction at this site is seen as the primary place at which experience in the praxis of psychiatric nursing is transformed into psychiatric nursing meaning or knowledge (Arthur, 1999; Fowler and Chevannes, 1998; Wilkes and Wallis, 1998).

The School of Nursing uses the curriculum-as-praxis, problem-based approach to accomplish the person-centered teaching/learning outcomes in the undergraduate nursing degree programme. Problem-based learning (PBL) sees clinical problems as the starting point for the process of meaning making within the nurse-client interaction. Problem-based learning moves, as does problem solving, from a question - "What is the problem" - through a series of steps to a final solution or product (Duchscher, 1999). It commonly requires students to articulate the following activities. These include searching the nurse-client interaction for problems overtly and covertly expressed by the client; identifying possible theoretical paradigms for underlying problems; developing a series of nursing actions consistent with client needs and theoretical frameworks; exploring the ethical and creative meanings underpinning client behaviours and nursing actions in practice; and finally, implementing and evaluating the outcome of nursing actions (Phillips, Fawns and Haynes, 2002; Pierson, 1998; Scanlan, Care and Udod, 2002).

The value of this approach in developing nursing practitioners who are able to competently solve clinical problems in practice is illustrated in the study by Uys, Van Rhyn, Gwele, McInerney and Tanga, 2004. These authors explored and compared the clinical problem solving abilities of nurses who had graduated from problem-based and non-problem based programmes in nursing schools in South Africa. The study found that those who graduated from problem-based programmes were generally more competent in solving complex clinical problems than those who graduated from non-problem based programmes. Whereas the former were able to integrate past experience with similar situations and to adapt their responses accordingly, the latter tended to respond to clinical problems as if for the first time and therefore, drew extensively on institutional rules to moderate their responses.

The PBL framework has been variously criticized for its linear and rational approach to meaning making and for its solution-oriented forms of nursing knowledge (Barker, Reynolds and Stevenson, 1997; Littlejohn, 2003; Paley, Shapiro, Myers, Patrick and Reid 2003; Pierson, 1998). Fredriksson and Eriksson (2003) argue that the caring conversation in nursing has been reduced to a problem-solving technique and a vehicle for the transmission of data. Pierson (1998) argues that problem solving directed primarily towards the instrumental analysis and solution of problems is inappropriate for contemporary nursing practice that emphasizes its social situatedness. Calculative-contemplative problem solving on the other hand, considers both the instrumental aspects of the problem itself, and the social context within which it occurs (Hyde, Treacy, Scott, Butler, Drennan, Irving, Byrne, MacNeela and Hanrahan, 2005).

Although Uys et al. (2004) (reported above) do not explicitly define their understanding of the cognitive processes underlying problem solving, their use of Benner's novice to expert levels of practice to categorize the nurse graduates problem-solving abilities suggests more than instrumental problem solving at work

here. However, this study does not speak to the issue of social situatedness and therefore it is difficult to determine if their problem solving is directed toward the problem and its social context or to the individualised aspects of the problem.

This section concludes with a brief description of the six-month PBL psychiatric nursing rotation undertaken by the undergraduate nurse-speakers[4] in these texts at the School of Nursing.

A one-week orientation period precedes clinical placements in the psychiatric community (clinics, hospitals and associated community organizations). Basic skills in calculative-contemplative reflective learning, self-exploration, empathic communication, psychiatric assessment and diagnosis are accomplished through a range of different simulation activities. For example, a case study that details both the psychiatric and personal experiences of mental illness for a hypothetical person and his family provides a route of entry into the psychiatric and personal world of mental illness and distress. Students' personal responses to the case study and to the idea of psychiatric nursing in general serve as one of the starting points for reflective learning Clouder and Sellars, 2004; Cook, 1999). Experiences are articulated, explored and clarified in class, and potential theoretical knowledge constructs identified. The student then uses these constructs for a basic nursing journal literature search and review, wherein he/she attempts to show how the theoretical data supports, explains, contradicts or develops his or her understanding of the dynamic of the described experience, and how this understanding might be transferred to other situations.

Once students enter the clinical field, this same framework is used in response to the clinical and intrapersonal issues they encounter in their clinical work with clients. Classes are held weekly for the duration of the rotation and serve as a repository for the preceding week's clinical encounters. Clinical supervision attempts

[4] See Chapter 3 section 3.5.1.2 for an explanation of 'nurse-speaker'.

to facilitate the student's entry and to a greater or lesser extent, the student-teacher interaction acts as a map for the student as she/he begins to navigate the nurse-client relationship in clinical practice (Gilbert, 2001). A humanist theoretical frame generally underpins the process where the focus is primarily on developing the nurses' interpersonal therapeutic competence in understanding the life world of the client as it is expressed in the specific interaction being supervised. The broader social and institutional reality within which the interaction occurs is not always a feature of clinical debriefing since the emphasis is on the interpersonal, micro-reality within which the participants are situated (Gilbert, 2001; Maxwell, 1997).

2.3.1 Conclusion

One of the criticisms of set and standardized approaches to teaching and learning is the extent to which they are regarded as vehicles for the development and transportation of neutral knowledge. Littlejohn (2003) and Paley, Shapiro, Myers, Patrick and Reid (2003) argue that a curriculum-as-praxis approach (or any other approach) is not a neutral medium for knowledge development but rather an active instrument that works to construct particular kinds of ways of seeing and particular kinds of knowledge. I have already noted in chapter one that psychiatric nursing students usually interpret their helplessness to inquire about and respond to the lived concerns of the client in the psychiatric interview as examples of their own inability to practice the person-oriented and interpersonal expectations of psychiatric nursing theory.

While the School's education framework uses the common concepts of nurse, client, environment and health to articulate its focus, it does not offer direction for how a critical understanding of the socio-political and institutional environments of health care may be appropriately integrated into the process of actively nursing people (Thorne et.al. 1998). It may well be that this entrenched and taken-for-granted focus on the individual as site of problem-solving activity is one of the forces

inadvertently obscuring the significance of the social context within this framework and therefore, aspects of its own holistic mandate (Browne, 2001; Stajduhar and Balneaves, 2001).

2.4. The modern idea (s) of psychiatric nursing

Modern explorations of psychiatric nursing cite the nurse-client relationship as the essential event in psychiatric nursing, as synonymous with psychiatric nursing and as the medium through which psychiatric nursing is made visible in practice. (Cameron, 2004; Cameron, Kapur and Campbell, 2005; Crowe, 2000; Forchuk, 1995; Forchuk and Reynolds, 2001; Hagerty and Patusky, 2003; Peplau, 1952, 1966, 2003; Roberts, 2004; Rushing, 1964; Shattell, 2004; Uys, 2004 [4]).

The term nurse-client relationship is most often used to refer to a cluster of activities - "person-centred", "communicative competence", "holistic care"- which are believed to reflect and to give meaning to the doings of psychiatric nursing in practice (Cameron, Kapur and Campbell 2005; Forchuk and Reynolds, 2001; Peplau, 1952; Roberts, 2004; Van Kaam, 1966). Person-centered care is generally understood to mean care tailored to and motivated by the individual's multidimensional health needs, values and preferences and to this extent, notions of holism are subsumed within it. Key components of person-centered care thus include: having a holistic or multidimensional perspective of the person; knowing the person as an individual; having a client-oriented working agenda and facilitating understanding of this agenda; facilitating decisional choice about health matters and reasonable risk-taking; establishing trusting, collaborative relationships; and facilitating appropriate family involvement and providing emotional support and comfort. Communicative competence references the nurse's ability to engage with the life world of the client and to use this engagement to facilitate the goals of psychiatric nursing. The goals of psychiatric nursing generally regarded as synonymous with or similar to this person-

centered agenda. (Cowling, 2004; Eckroth-Bucher, 2001; Edwards, 1999; Ferguson and Hope, 1999; Forbes, King, Kushner, Letourneau, Myrick and Profetto-McGrath, 1999; Hyde, Treacy, Scott, Butler, Drennan, Irving, Byrne, MacNeela and Hanrahan, 2005; Peplau, 1952; Roberts, 2004; Talerico, O'Brien and Swafford, 2003; Taylor, 2003).

A wide range of therapeutic communication strategies is believed to sharpen the therapeutic potential of this person-centered agenda. The communication skills of empathic attending and responding – of hearing client-centered needs and meanings and of reflecting this understanding to the client in ways that facilitate greater insight - are commonly associated with the therapeutic potential of this process (Morse, Bottorff, Anderson, O'Brien and Solberg, 2006; Uys, 2004 [4]). Other and similar renderings of the skills and qualities that constitute a therapeutic person-centered relationship have been extensively documented (Beeber, Canuso and Emroy, 2004; Forchuk and Reynolds, 2001; Grant 2001; Reynolds, Scott and Austin, 2000; Yegdich, 1999). Three findings from more recent studies are briefly outlined here to illustrate this consistency of understanding.

McCann and Baker (2001) explored the communication practices of community mental health nurses and found that a number of specific strategies significantly enhanced the development of reciprocal interpersonal relationships between themselves and young adult clients. These include: attempting to understand the person, being friendly, revealing aspects of oneself, tuning in to the life-world of the person, being there for them in moments of transition and maintaining confidentiality. Williams and Irurita (2004) found that hospitalized clients experienced increased emotional comfort when professional staff embodied qualities of competence, availability, information-giving and verbal and non-verbal engagement in their encounters with them. These clients associated increased emotional comfort with an increase in their potential for healing and recovery. Forchuk and Reynolds (2001) used client-views of what nurse-behaviours constitute

a helping relationship to develop a measure of empathy in interaction. Nurse-behaviours traditionally associated with the humanist idea of empathy such as the exploration and clarification of feelings and personal meanings, a focus on the here and now, a solution-focus that reflects the client's preferences and lifestyle and a manner that suggests warmth, openness, attentiveness and respect, figured prominently in their views.

Most scholars agree that the therapeutic skills and effect of the person-centered nurse-client relationship evolves over time and through the medium of different stages, each with its own characteristic but overlapping elements and tasks (Hagerty and Patusky, 2003; Forchuk and Reynolds, 2001; Latvala, 2002; McQueen, 2000; Orbanic, 1999). Stages of this interpersonal process include a beginning or orientation phase, middle or working phase and an ending or termination phase while the activities of person-centered care alluded to in the previous paragraph give the process its therapeutic focus (Gastmans, 1998; Hagerty and Patusky, 2003; Heifner, 1993; Talerico, O'Brien and Swafford, 2003). Although these person-centered activities have been variously defined, almost all of the definitions are drawn from a seminal work in the area, undertaken by Peplau in the early 1950's.

Peplau's (1952) work, entitled "Interpersonal Relations in Nursing" is regarded as the first systematic theoretical framework in psychiatric nursing (Forchuk, 1995; 2003). Peplau's theory and subsequent frameworks are more often than not, grounded in humanistic principles which are believed to articulate the person-centered nursing mandate. Humanism is a facet of modern social theory that privileges the sovereignty of the individual "self" in social life (Browne, 2001; Forchuk and Reynolds, 2001; Forchuk, 2003; Hagerty and Patusky, 2003; Hardin, 2001; Kottow, 2001; Littlejohn, 2003; Lont, 1995; Montgomery and Webster, 1994).

Similarly, the person-centered mandate privileges the client-self as the site of care and the nurse-self as the instrument of this care. This idea of the sovereign self

and its potential implications for the theoretical and clinical doings of psychiatric nursing are pursued further in section 2.4.3.

This section has provided an uncritical account of how the person-centered approach is conceptualised in psychiatric nursing literature. This next section shows how this person-centered ontology is taken up as the essence of practice in the discipline's descriptions of what it is that psychiatric nurses do.

2.4.1 The centrality of the person-centered doings of psychiatric nursing in praxis

Mental health nursing research studies over the past fifty years suggest that experienced psychiatric nurses, student psychiatric nurses, nurse researchers, textual descriptions of psychiatric nursing and consumers regard the process of establishing and maintaining a therapeutic, person-centered relationship as the quintessential psychiatric nursing activity (Bugge, Smith and Shanley, 1999; Crowe, 2000; Gastmans, 1998; Hagerty and Patusky, 2003; Forchuk, 2003; Fredriksson and Eriksson, 2003; Latvala, 2002; Leighton, 2005; O'Brien, 2001; Peplau, 1952; Peplau, 2003; Rushing, 1964; Shattell, 2004; Van Kaan, 1966; Williams, 2001).

This construction of psychiatric nursing as a therapeutic, holistic, person-centred, interactional process is central to the identity of psychiatric nursing as a discipline (Roberts, 2004; Eckroth-Bucher, 2001). Nursing scholars offer diverse and convincing accounts for why a modern person-centered paradigm is regarded as nursing's unique mandate. For example, Hopton (1997), Jacobs (2001) and Littlejohn (2003) suggest that its humanistic stand-point places the nursing mandate in direct contrast to the positivist, body part mandate of medicine and in so doing, highlights itself as a distinctive entity in the landscape of health care. Jacobs (2001) and Saporiti Angerami and Correia (1997) suggest that holism in nursing has a political and moral function in health care because it works to weave "back together again" people

fragmented by a specialist body-part approach to health care. On the other hand, Mulholland (1995) argues that humanism is the natural evolutionary end-point of a mature nursing praxis. Most modern nursing scholars agree that it is precisely this construction that differentiates psychiatric nursing from general nursing and from the "cure-case" orientation in medicine and in so doing, contributes to its autonomy as a profession (Browne, 2001; Orbanic, 1999).

The opportunity to engage autonomously with this process is usually cited by experienced psychiatric nurses as their reason for entering and for remaining in the discipline (Baker, Richards, and Campbell, 2005; Cunningham and Slevin, 2005; Kipping, Gary and Hickey, 1998 [1]; Ferguson and Hope, 1999; Leighton, 2005). This group reports other multidisciplinary nursing activities as occurring frequently - presenting observations of clients to doctors, giving medication, socialising-agent and secretarial activities – but unlike the nurse-client relationship, these activities are not universally regarded as foundational to the practice of psychiatric nursing (Crowe, 2000; Cutcliffe, 1997; Hagerty and Patusky, 2003; Leighton, 2005).

Student nurses engaging with psychiatric nursing generally define it as "different" from other nursing, specifically with respect to the emphasis given the nurse-client relationship in the psychiatric nursing process (Ferguson and Hope, 1999; Granskar, Edberg and Fridlund, 2001). This difference is most often defined in positive terms such as having more time to talk with clients, more one-to-one involvement, and more opportunities to make decisions about client care based on an interactional relationship (Ferguson and Hope, 1999; Rungapadiachy, Madill and Gough, 2004). The nurse-client relationship is seen as both the point of entry to psychiatric nursing and its working territory (Rungapadiachy, Madill and Gough, 2004).

Nurse researchers working in the substantive area of psychiatric nursing knowledge development most often situate their research question within the context

of the nurse-client relationship, or at least, within the principles and practices believed to articulate this relationship (Forchuk and Reynolds, 2001; Fredriksson and Eriksson, 2003; Fredriksson and Lindstrom, 2002; Gastmans, 1998; Hagerty and Patusky, 2003; Jonsdottir, Litchfield and Pharris, 2004; Shattell, 2004). Examples include theoretical analyses in the areas of autonomy (Aveyard, 2000; Keenan, 1999); trust (Hupcey, Penrod, Morse and Mitcham, 2001) empowerment (Chamberlain, 1997; Falk-Rafel, 2001; Fingeld, 2004; Ryles, 1999), empathy (Orbanic, 1999; Reynolds, Scott and Austin, 2000; Sutherland, 1993; Yegdich, 1999), caring (Cumbie, Conley and Burman, 2004; Fagestrom, Eriksson and Engberg, 1998; Fealey, 1995; Fredriksson and Eriksson, 2003; Kellet and Mannion, 1999; Paley, 2001; Smith, Alderson, Bowser, Godown and Morris, 1998), and cultural diversity (Baldwin, 2003; Campinha-Bacote, 2003; Sorrell, 2003; Zwane and Poggenpoel, 2000). Even those few studies within the South African literature, concerned with explicating the relationship between the broader socio-political reality, health policy and psychiatric nursing, make reference to the consumer-provider relationship as a significant site of mental health care delivery (Muller and Poggenpoel, 1996; Uys, 1991; 1994; Uys, Subedar and Lewis, 1995).

It is hardly surprising therefore, that psychiatric nursing is described primarily as an interpersonal, person-centered process in national and international psychiatric nursing text books. For example, Haggerty and Patusky (2003) reviewed ten recent editions of currently used psychiatric nursing text books and found that all the authors conceptualised the nurse-client relationship and its elements in the same way. Resonances with this holistic, person-centered perspective can be easily identified in the South African literature and specifically, in Uys's (2004 [4]) conceptualisation of psychiatric nursing; in Poggenpoel's (1996) description of the relevance of the "whole person" theory for psychiatric nursing and research, and in Arunachallam, Botes and Gmeiner's (2000) description of a community-based curriculum in psychiatric nursing science for a nursing college in KwaZulu-Natal. Resonances with this position are further evident in the South African Nursing

Council regulations and directives for psychiatric nurse education that define the process of psychiatric nursing as a holistic, individual-oriented endeavour, concerned primarily with the mental health needs of the person/community.

Consumer and provider perspectives of the clinical relevance of the therapeutic, person-centred relationship have been well described (Forchuk, 1995; Forchuk and Reynolds, 2001; Forchuk 2003; Jonsdottir, Litchfield and Pharris, 2004; Stickley and Freshwater, 2002; Williams and Irurita, 2004). Forchuk (1995) and Forchuk and Reynolds (2001) cite a variety of studies in the disciplines of psychology and psychiatric nursing, all of which demonstrate a clear association between client positive health outcomes and the therapeutic relationship. Consumer perspective research findings suggest that the psychiatric nurse's ability to empathise with the life and illness experiences chronicled by consumers positively influences the manner in which they negotiate the process of recovery (Eakes, 1995; Forchuk and Reynolds, 1999; Shattell, 2004; Wolf, 1997).

Finally, there seems to be consistency across qualitative studies situated in different continents and contexts about the value of person-centered behaviours for psychiatric consumers. Adam, Tilley and Pollock (2003) [United Kingdom] found that community-based consumers valued the personalized relationships they shared with community psychiatric nurses and that relationships focussed on the agenda and needs of the individual person served a distinctive purpose in their general social network. The study also found that consumers valued the nurse's skills of forming and maintaining a long-term relationship of personalized care and purposive talk, more highly than technical skills and therapeutic interventions.

Yonge (2002) [Canada] explored eight acute care in-patient psychiatric clients perceptions of constant psychiatric nursing care and found that the nurse's presence and what they were like as people was more important than technical or other skills associated with nursing. Clients had a strong preference for nurses who were

understanding, respected their privacy, and were quite, calm and non-blaming and suggested they tended to "behave more" around this kind of nurse than around nurses who were moody, silent and self-centered.

Forchuk and Reynolds (2001) explored the factors hospitalized psychiatric clients in Scotland and Canada perceived as contributing to the development of the nurse-client relationship. The findings from both sites suggest that clients regarded a positive nurse-client relationship as the basis of their in-patient care and that the caring characteristics of the nurse, the manner in which interactions were conducted and the implementation of plans between meetings are significant to a positive relationship.

Hautala-Jylha, Nikkonen and Jylha (2005) [Finland] found that psychiatric out-patient clients regarded a confidential, co-operative relationship with an out-patient nurse as one of the critical factors in promoting their own continuity in care after discharge from a psychiatric hospital. Poggenpoel (1997) [South Africa] explored thirteen hospitalized clients internal world experience of interacting with psychiatric nurses and found that nurse caring and friendliness are perceived by clients as an important aspect of their experience of psychiatric nurses.

2.4.1.1 Conclusion

This section has provided some understanding of how the person-centered nurse-client relationship is constituted in modern scholarship. Suggestions in studies derived from the perspectives of consumers, providers, families and nurse scholars were used to support the construction of psychiatric nursing as a person-centered, interpersonal process, commonly understood and expressed as the essence of psychiatric nursing in contemporary nursing literature.

2.4.2 The invisibility of the rhetorical[5] doings of psychiatric nursing in practice

In this section it will be suggested that although the person-centered nurse-client relationship is regarded as the discipline's quintessential role, this role is not as visible and as normative in practice as it is in the rhetoric of psychiatric nursing (Armstrong, 1995; Beeber, Canuso and Emroy, 2004; Beresford, 2004; Blackford, 2003; Browne, 2001; O'Brien, 2001; Crawford, Johnson, Brown and Nolan, 1999; Thorne, Canam, Dahinten, Hall, Henderson and Kirkham, 1998).

Some contemporary psychiatric nursing research studies are beginning to suggest that the observed interactional work of mental health/psychiatric nurses is given less priority than non-interactive activities; that it lacks therapeutic competence and that institutional habitus rather than the person-centered rhetoric directs practice. Findings from studies exploring client, family and professional perceptions of psychiatric nursing add substance to this argument. These studies are beginning to illuminate this dissonance between what is reported and what is observed to occur in different practice settings such as acute, long-term and out-patient settings. (Cameron, Kapur and Campbell, 2005; Forchuk and Reynolds, 2001; Fredriksson and Eriksson 2003; Gilbert, 2001; Koivisto, Janhonen and Vaisanen 2004; Latvala, Janhonen and Wahlberg, 1999; Lilja, Ordell, Dahl and Hellzen, 2004; Nelson and McGillion, 2004; Robinson, 1996; Shattell, 2004; Skidmore, Warne and Stark, 2004; Sloan and Watson, 2001; Talerico, O'Brien and Swafford, 2003; Williams and Irurita, 2004; Wortans, Happell, Johnstone, 2006).

Experienced psychiatric nurses working in in-patient contexts seem to spend approximately 60-80% of their working time engaged in administrative,

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[5] Rhetoric is defined in the way of Billig as the language of a specific theoretical perspective (Billig and Schlegoff 1999).

organisational and non-nursing related tasks. Furthermore, activities associated with the interpersonal core of psychiatric nursing are frequently devolved to less qualified staff and while clients report wanting contact time with experienced nurses, they are generally perceived as 'too busy to talk' (Gijbels, 1995; Jackson and Stevenson, 2000; Jones [2], 2005; Robinson, 1996; Rungapadiachy, Madill, Gough, 2004; Ryrie, Agunbiade, Brannock and Maris-Shaw, 1998; Wortans, Happell and Johnstone, 2006). A number of studies illustrate these points.

Robinson (1996) recorded over one hundred thousand detailed observations of psychiatric, forensic and general nursing activity using time sampling techniques. The analysis showed clear and considerable similarities between the three nursing contexts with respect to nursing time and client interaction. Approximately 62 percent of experienced (senior) nursing time was absorbed by a range of administrative and supervisory tasks that had very little to do with the relational core of psychiatric nursing. Although direct, individualised care accounted for 35 percent of nursing time, most of these activities were carried out by less qualified staff such as nursing auxiliaries. In a similar study, Ryrie, Agunbiade, Brannock and Maris-Shaw (1998) observed the working practices of psychiatric nurses on two acute psychiatric wards with reference to the amount of time available for direct client contact. These authors found that the psychiatric nurses spent approximately 52-55% of their time engaged in administrative and non-nursing duties, such as sourcing beds in other institutions. Further, responsibility for therapeutic engagement with clients was devolved to junior staff.

More recently, Kristiansen, Dahl, Asplund and Hellzen (2005) investigated the connections between psychiatric nurses' opinions of client behaviour and social functioning and the time spent together. The study found that psychiatric clients spend an average of 20% of their daily time together with the staff. Further, those clients who were evaluated as having a low level of social functioning and a high

degree of psychiatric symptoms – the most vulnerable and dependant client group - received less staff attention (18%) and spent 71.4% of their time alone.

Another recent study by Jones ([2005 [1]) adds substance to the argument being developed here and inadvertently illustrates this dissonance between the rhetoric of the person-centered approach and institutional practice. This study investigated how mental health nurses went through the process of developing and implementing a therapeutic care pathway for people diagnosed with schizophrenia on hospital wards. Although this study works with staff descriptions rather than with identifying and measuring directly observed interpersonal care behaviours, the researcher's observations of staff behaviour vividly contrast with these reports. On the one hand, all the respondents reported that knowing the client, using interpersonal skills and spending therapeutic time with psychiatric clients constituted the basic therapeutic activities of such a care pathway. On the other hand, the researchers own observations suggested that nurses tended to congregate in the nursing office and to approach clients only for specific tasks such as medication administration.

Symptom and illness-focussed approaches to care commonly underlie psychiatric nursing practice in both hospital and community settings (Hopton, 1997; Gijbels, 1995). For example, Latvala, Janhonen and Wahlberg (1999) explored the extent to which psychiatric nursing care enabled rather than disabled psychiatric in-patient client involvement in the care process. An enabling, patient-oriented approach to care is defined in this study as a mutually determining relationship, initiated by the nurse and sustained through participatory dialogue, the interactional principles of consultation and negotiation and a shared focus of the client's life-world experiences. Video-taped observations of nursing report and planning meetings and staff interviews were used to generate data.

The analysis found that the most frequently occurring type of psychiatric nursing practice reflected an authoritarian stance with a medicalised approach to

care, a medicalised understanding of illness, a symptom-focused approach to interaction and a medication compliance approach to nursing intervention. Clients were generally positioned as non-involved, passive recipients of the care process and the nurses as knowledgeable experts. Similarly, Lilja, Ordell, Dahl and Hellzen (2004) found that nurses working in both in-patient and community settings displayed a symptom-focussed approach in their interactions with their clients, even when interacting with clients they perceived as "good" (that is, as unproblematic and trustworthy).

This dissonance between the person-centered rhetoric of psychiatric nursing and institutional practice is also emphasized in studies involving psychiatric nursing students perceptions of what it is that psychiatric nurses do. For example, Rungapadiachy, Madill and Gough (2004) explored mental health nursing students' (n=14) perceptions of the role of the psychiatric nurse during their psychiatric clinical rotation. The analysis of the semi-structured interviews showed that while students observed experienced nurses performing in a variety of roles, priority was given to the administrative tasks of paper work, documentation and medication control. Spending time with clients was not seen as a priority and opportunities for engagement were actively ignored. Some experienced nurses were perceived to behave in ways that suggested malpractice, demonstrated a lack of skill in handling client problems and suggested a negative approach to care. There were frequent references to staff spending long periods of time sitting in the office drinking tea and gossiping; hiding away in tense situations on the ward and demonstrating a "why bother attitude" in response to suggested innovations.

Findings from client and family interpretive studies add further substance to this argument for a dissonance between rhetoric and practice. For example, while the studies undertaken by Dornbos (2001), Eakes, (1995), Forchuk and Reynolds (2001) demonstrated a positive relationship between the nurse-client relationship and client health outcomes, they also found that clients and family members more frequently

[my emphasis] perceive mental health nurses as non-caring, as actively excluding them from the process of care, as blaming of the family for the client's illness and as failing to give them the required emotional support and information they need at the time they need it.

For example, Dornbos (2001) investigated the amount of practical and emotional support caregivers of people with serious mental illnesses received from professional care-givers. The analysis showed that between 20 and 50% of care-givers (n=126) reported never having received affective or instrumental support from care-givers. Of those who did receive some form of support, 45% said they had not received any advice for future planning, 41% received no assistance in identifying support resources for themselves, 38% had never been given any behavioural management advice and 33% were without advice for handling emergencies. However, 31% of the respondents experienced a non-blaming attitude from nurses that these authors suggest is a significant improvement although no contrasting percentage is offered to examine this assertion.

Wallace, Robertson, Millar and Frisch (1999) explored service user and family perceptions of the care and services they had received from the in-patient and out-patient departments of the same institution. These authors used the constructs of quantity and quality of care, individuality and partnership to analyse the data generated from seven focus groups with family members (n=28) and clients (n=23). The analysis shows that while a few positive features are mentioned with respect to quality and quantity of care, negative comments were more frequently noted, particularly across the domains of individuality and partnership. The majority of comments revolved around disrespect for the needs of family members and clients, being medicated without consent, being rudely treated and not being listened to, and having confidentiality broken. Clients and families reported feelings of powerlessness and incompetence with respect to their involvement in the process of care. Although family members saw themselves as a resource, they were not used in

this way and felt demeaned and uninvolved. Inactivity was cited as one of the most demeaning features of the quantity of care, specifically the absence of any form of therapeutic activity.

The authors of the following two separately reported studies used a phenomenological approach in each case to explore clients' perceptions of how health processes are promoted in mental health nursing (Svedberg, Jormfeldt and Arvidsson 2003) and to describe psychiatric nurses' conceptions of how health processes are promoted in mental health nursing (Jormfeldt, Svedberg and Arvidsson 2003). It is difficult to distill the authors' precise understanding of the construct health processes from the report. However, it seems to include a focus on promoting and strengthening the mental health quality of life of psychiatric clients and on facilitating their active participation in this process in mutually inspiring and empowering ways.

Data from the nurse group were analysed in terms of three core categories of strategies nurses regarded as promoting health processes in nursing care. These included **presence**, that is, being aware of and seeing the client, being committed, personal and providing security to the client; **a balance of power** (between using societal and disciplinary norms to normalize behaviour and collaborating with and support client-choices); and **a focus on health promotion** that is, trusting in the human potential and focusing on client strengths and resources. The analysis suggests that in the main, these nurses were not aware of the person-centered focus of the nursing mandate, were ambiguous about how best to know their clients, believed it their responsibility to use institutional norms to regulate client behaviour irrespective of client wishes and were uncertain about the belief in the extent to which human capacity can grow (Jormfeldt, Svedberg and Arvidsson 2003).

Data from the patient group about how health processes may be promoted in nursing care were summarized into four descriptive categories. These included

interaction (to trust, to feel mutuality and to enter into a personal relationship), attention (to feel noticed and to feel the nurse's commitment and accessibility) and development and dignity (to gain hope, to see new possibilities, to have one's good qualities recognized, to obtain knowledge and to be confirmed). The analysis suggests that in the main, the health of clients is not systematically promoted in mental health nursing. Ten out of the eleven clients interviewed reported experiences of having their dignity violated and of not having their resources and strengths recognised. The authors suggest that their findings show that clients need to be treated as equals and that nurses must trust in the client's abilities to make decisions and to take action to promote his/her health process (Svedberg, Jormfeldt, and Arvidsson 2003).

What then do people need psychiatric nurses for? Jackson and Stevenson (2000) used a grounded theory methodology to explore what people in contact with mental health services need nurses for and their perception of what psychiatric nursing activity would meet those needs. The views of psychiatric nurses, social workers, psychiatrists, clients and carers were included in the study (n=92). Their analysis is very detailed but two points are significant here. The first point is that the theory of what people need psychiatric nurses for revolves around the core category 'knowing you, knowing me'. This core category describes clients and professionals expectations that nurses are best positioned to understand the life world of the client and more specifically, to know how the client wants the nurse to respond *given* the client's particular understanding of her/his life world. Their model of this core category describes three domains of being "me"- of ordinary friendliness, engineered friendliness and a professional stance- each of which outlines the kinds of professional activity nurses might need to draw upon to meet client needs. Activities within each domain are further described with respect to structuring of time, the kind of language used and the depth of knowing the client. Whichever "me" the nurse is operating within will affect the way the nurse relates to the client.

The second point of interest here is who and which group of nursing staff is more likely to be charged with doing the knowing? It seems that the more senior the nurse, the less time they spend with clients, the more they operate within the professional-me domain and the less ordinary-me personal knowledge they develop about their clients. The study found that this knowledge was generally limited to the more junior and/or untrained nurses who spent more time with clients and knew more about them but had less experience and knowledge of theoretical-based practice to respond predicatively to their complex needs. There were many references in this study to nurses not being available to clients on the ward because they spent almost all their time in the office and to clients not being willing to interrupt the busyness of senior nurses.

2.4.2.1 Conclusion

These exploratory studies of the doings of psychiatric nursing and how clients and family members experience them are beginning to suggest a dissonance between the person-centered rhetoric of psychiatric nursing and institutional practice. This dissonance has been previously identified – around the early 1970's - as the theory/practice gap. Recommendations for closing this gap generally revolved around re-inscribing the centrality of the individual, person-centered approach in care through further training and in-service education in these nurse-client skills. The interpersonal skills training courses introduced by the South African Department of Health in the 1980's for psychiatric nursing staff in institution and community settings is one example. Similarly, many of the studies reviewed in sections 2.4.1 and 2.4.2 recommend further and more complex person-oriented skill training programmes to address deficiencies in the visibility of this approach in individual nursing practice.

While many of these studies do recognize the impact the institutional,

administrative and clinical environment might have in enabling and constraining the application of specific skills, the responsibility for changing practice **in spite of these factors** almost always lies with the individual nurse. This focus on the individual as the site and source of the troubles in articulating the rhetoric of psychiatric nursing is entirely consistent with its modernist paradigmatic influences. The next section (2.4.3) offers a brief account of these influences and considers their implications for psychiatric nursing going on together in conditions of relationship.

2.4.3 Modern social theory and its Implications for the visibility and invisibility of person-centered doings in practice

Modern social theory locates the origin of thought, feeling, experience and knowledge within the individual self (Gergen, 1999). A prominent idea about the self is that the individual is capable of observing the self and the world for its essential truths, of evaluating and interpreting these observations for their unique, individual meanings and thereafter, of using these observations as a basis for rational, informed decision-making and socially appropriate behaviour (Gergen, 1999; Haber, 1994; Hardin, 2001). This perspective therefore regards the self as exterior to rather than embedded within a social, economic, political or historical context and thus, capable of creating rational meaning out of and acting upon the broader social context (Gergen, 1999). Although modern social theory underscores the dialogical relationship between the self and social context, the sovereignty of the self in social life suggests that the primary emphasis is on the individual and the extent to which he/she acts in a self-directed, self-responsible manner with the broader social context (Haber, 1994; Thorne et. al. 1998).

Finally, a corollary of this version of the disembodied, rational and observing self is of the self's innate propensity for self-determination which includes the

processes of personal freedom, choice, responsibility and mastery (Gergen, 1999). Self-determination is regarded as a pre-cursor to freedom, personal happiness, growth and the realization of innate potential. To this end, the individual's innate capacity for introspection enables him/her to "stand aside" from the self and to identify personal, physical, emotional, spiritual or social requirements that might impede and/or facilitate the realization of the related goals of self-determination (Hesook, 1999; Hewison, 1995; Warne and Stark, 2004). The idea of self-determination suggests that it is the individual rather than the individual-and-context who is held accountable not only for what and how decisions are made but also for their personal and social consequences (Haber, 1994; McHoul and Grace, 1993; Smart; 1985).

2.4.3.1 Implications for the doings of psychiatric nursing

The sovereignty of the self-determining "self" in every day life, together with its capacity for distilling essential a-priori truths about reality from experience and for using these in the pursuit of self-directed growth and mastery, are central to the premise of person-centered psychiatric nursing theory (Gergen, 1999; Hopton, 1997; Jonsdottir, Litchfield and Pharris, 2004; Littlejohn, 2003).

The first implication of this modern understanding is that it is the self that is the primary site of psychiatric nursing practice and source of psychiatric nursing knowledge. Although there are different versions of the self within a modern paradigm of nursing - whole person or multidimensional persona - the constitutive effects of modern social theory are articulated in the ways in which the client-self and nurse-self are privileged as the source and site of psychiatric nursing knowledge and action (Jacobs, 2001; Jonsdottir, Litchfield and Pharris 2004; Leighton, 2005; Orbanic, 1999; Thorne, et. al., 1998). While humanism acknowledges that dissonances within the self are consequential to dissonances within the self-environment interaction, the self is seen as responsible for these dissonances and again, it is the self rather than

context that is the primary site of psychiatric nursing practice and knowledge (Crowe, 2006; Hardin, 2001; Kottow, 2001; Lont, 1995; Montgomery and Webster, 1994; Thorne et. al., 1998.)

The second implication of this modern understanding of the self is the authority of the nurse-self in articulating the nursing mandate in practice. The ability of the nurse to instrumentalise her "self" as an agent of the nursing mandate is regarded as the quintessential activity of person-centered nursing (Eckroth-Bucher, 2001; Li, 2004). Whereas the client's self is seen as the site of therapeutic intervention, the nurse's self is viewed as the instrument of this intervention or as Newman (2002) suggests, the means whereby clients emerge as a unified transformation of themselves (Eckroth-Bucher, 2001; Forchuk, 1995; Heifner, 1993; Newman, 2002; Orbanic, 1999; Peplau, 1952). Difficulties in implementing the nursing mandate are framed as a consequence of some deficiency in this instrumental self and are correspondingly addressed. This is not to underscore the ethical responsibility individuals have for developing required skills or that sustained skill training programmes are inappropriate for addressing deficiencies. Rather, that responsibility for action is diverted away from the institutional context to the individual within that context.

The third implication for this view of the self is that it obscures the role of social context in constituting what happens at the site and source of psychiatric nursing practice. Social context is an umbrella term and it is used in this study to reference those social forces which are more obviously at work than others within a particular setting (Browne, 2001). The more obvious forces at work within the setting in which these texts were generated have been described in the previous sections as the institutional context, the problem-solving curriculum as praxis context and the modern theory of psychiatric nursing context. Nursing's metaparadigms were used to identify these contexts as more obviously at work. The problem-based and public health contexts were taken as the most obvious environmental forces at work while

the paradigms of the nurse, client and meanings of health and illness were seen to be subsumed with the writings of modern psychiatric nursing theory and at work within these texts.

One of the criticisms of modern nursing and psychiatric nursing is its inattention to the effect of institutional context in shaping and resourcing the doings of psychiatric nursing in practice (Browne, 2001). Nursings' close association with the bio-medical model in general and in public health care contexts has been well described and critiqued (and in this study too). Jonsdottir, Litchfield and Pharris (2004) and others (Haggerty and Patusky, 2003; O'Brien 2001; Williams and Irurita, 2004) have extended this argument to address the increasing reliance on evidence-based practice as a means of addressing the issues of staff shortage, cost-containment and demonstration of output in mental health services.

These authors argue that western health service systems increasing reliance on evidence-based practice, which draws almost entirely on the epistemology of the positivist paradigm, may further alienate the modern nursing mandate. The majority emphasis in evidence-based practice is on developing standardized, cost-effective and task-oriented procedures for managing a range of bodily needs. These authors suggest that the principle underlying these actions parallels the disease/treatment model of medicine that regards the body as an object of pathophysiology and is largely indifferent to distinctive health responses. The argument here is that increased reliance on direct outcomes for evidence of care puts the interpersonal work of the nurse at a disadvantage. These actions are very difficult to measure because they are hidden within the activities of nursing (Haggerty and Patusky, 2003; O'Brien 2001; Jonsdottir, Litchfield and Pharris, 2004; Williams and Irurita, 2004). Psychiatric nursing is therefore much more likely to approach dissonances in client well-being in the same instrumental, linear way in those systems where the body-part evidence-based approach to practice predominates. This is not to suggest that the necessity for medical treatment and sound practice is being questioned but

rather, the limiting of health care to standardized procedures which have the potential to undermine the relational and human-centered core of nursing and psychiatric nursing practice (Boutain, 1999; Williams and Irurita, 2004).

The final implication of this modern understanding of the self is of the authority of this understanding in the knowledge generating activities of psychiatric nursing (Jacobs 2001; Hopton, 1997; Newman, 2002; Thorne, Canam, Dahinten, Hall, Henderson and Kirkham, 1998). A variety of nursing and other scholars suggest that the idea of the individual self is so closely woven into the construction of Western society as to make it almost impossible to recognize the extent to which it shapes contemporary social, political and scientific assumptions (Browne 2001; Haber, 1994; Leighton, 2005; Mulholland, 1995; Thorne, Canam, Dahinten, Hall, Henderson and Kirkham, 1998). Heslop and Oates (1995) argue that the knowledge generating techniques of modern social theory – the cognitive abilities of the self to identify, define and describe the essential truths of a particular reality - have become institutionalised within nursing and nursing research. While these techniques were originally taken up by nursing to give the process a rational and scientific structure (and therefore, political credibility), they have inadvertently contributed to the development of a particulate and individualistic, linear cause-effect understanding of nursing and human health responses (Cowling, 2004; Nelson and McGillion, 2004; Newman, 2002; Patterson, 1998).

Cameron, Kapur and Campbell (2005) suggest that the person-centered nurse-client relationship has come to be institutionalised as an a-priori construct in psychiatric nursing and nursing research. These and other nursing scholars argue that knowledge generated from this paradigm usually re-iterates rather than contests the presence of these constructs and in so doing elevates them to the status of "truth" and places them outside the ambit of investigation (Cowling, 2004; Fredriksson and Eriksson, 2003; Nelson and McGillion, 2004; Newman, 2002; Paley, 2001). Paley describes this process of reification within the area of caring research "... as an

endless project, whose monotony is matched only by its uselessness." (2001, p. 196.). Paley suggests that a possible outcome of this reification process is an accumulation of homogenous knowledge that is incapable of producing divergent accounts and therefore, incapable of being contested. Clients do not always want to talk and this client-centred approach has been recently criticized for its privileged assumption that psychiatric nurses must help clients to talk about (excavate) their problems (Jonsdottir, Litchfield and Pharris, 2004; Shattell, 2004).

A similar challenge may be offered in respect of those psychiatric nursing studies that abstract the constructs – person-centered nurse-client relationship - from the process of investigation itself. England's (2005) exploratory study of the effective elements of nurse conversation is one such example. The argument for the focus of this study is that while much of the work of nursing constitutes and is constituted in conversational practices, insufficient attention is given to research communication strategies captured from actual nurse conversations with clients.

The author suggests that conversational work is "best captured as it happens and in a format that best represents the interaction patterns and goals of nursing" (p. 661). The data for the study was derived from a process recording of one nurse's conversation with a long term resident on a health care unit. This process recording was developed around two thematically meaningful principles believed to best capture and represent psychiatric nursing practices: a pragmatic analysis of deliberative nursing actions and a reflective analysis of the deliberative use of self in initiating and terminating person-oriented conversations. A process recording is defined here as an immediately reported memory of a conversation recorded according to particular written guidelines (not given in the report but available from the author).

The reported conversation was subsequently divided into topical segments. 162 segments were identified, 74 of which were ascribed to the nurse. Variable names

and classification codes from seven typologies were used to represent the communication actions at work in these 74 nurse segments. These seven typologies enabled the nurses' communication actions to be represented as firstly, structural communication techniques such as requestives (imperative requests) and secondly, as the presence of a psychiatric nursing communication micro-strategy. The third typology represented communication actions as elements of the nursing process (assessment, planning and so forth) and the fourth typology as content themes related to the core values of person-centered nursing. Communication actions were represented by the fifth typology as elements of nursing role behaviours such as educator, counsellor, and by the sixth as characteristic of a particular stage in the nurse-client relationship. The seventh typology described these communication actions as therapeutic or not in moving the conversation forward.

The nurse's actions in this nurse-client interaction were found to be consistent with those of the orientation phase of the nurse-client relationship with the nurse functioning as leader and resource person 83% of the time. There was a fairly even distribution of structural communication techniques in the professional discourse of the nurse. Sixty-six of the 74 nurse communication acts were rated as both therapeutic and effective. In these therapeutic and effective segments, the core values of psychiatric nursing, and specifically, initiating and maintaining the person-centered focus of the conversation and qualities of trust, were visible. Twenty-three (23) communication acts were identified as ineffective although one half of these were rated as having therapeutic value. Thirteen acts were rated as both ineffective and non-therapeutic and showed a problem with the action structure e.g. being disjointed and incoherent, and with the action form e.g. disregarding client-oriented meanings in uptake statements. Further, the activities of the nursing process were adequately represented in the segments with increased emphasis on assessment (31%) and intervention (48%). Between half and three-quarters of the nursing process elements in the segments were found to be therapeutic and effective.

The author suggests that the methodology and results of this study legitimize Peplau's view of nursing as an interpersonal, educative process. This claim is hardly surprising given that the process recording was a record of a memory of a conversation and was organised around a complex set of a-priori interpersonal constructs. It is possible that different insights might have emerged if the author had used actual conversations rather than second order (talk about the talk) reports of conversations. Although transcription is a form of analysis (as will be shown in Chapter 3), a description of talk that has taken place is a form of second order reporting that is produced from and within the author's particular moral and professional order of speaking (Harre & van Langenhove, 1999; Moghaddam, 1999).

It is therefore possible to argue that this study contributes to the already large and homogenous body of knowledge of the person-centered essence of modern psychiatric nursing. Of course, this same criticism may be leveled at this study – it is produced within and from my own moral order of speaking which in this case, is social constructionism.

2.4.3.1.1 Conclusion

It would seem that a particular understanding of psychiatric nursing as the nurse-client relationship, articulated within a humanist frame and developed by Peplau in the early 1950's is more often than not, reiterated in current understandings of psychiatric nursing and the process of psychiatric nursing knowledge development. That this is the case is consistent with the function of an overarching theory such as humanism, whose function is to provide a universal, seemingly neutral, a-contextual frame for understanding the practices of psychiatric nursing.

2.4.4 Other knowledges for psychiatric nursing practice

There is however, a growing body of discussion in contemporary nursing and psychiatric nursing journals about the need for different and more socially responsive perspectives on nursing (Thorne et.al., 1998). These have historically included the Foucauldian post-structuralist approach and more recently, discourse analytic approaches of varying kinds. Some examples of these discussions are given. Stevenson (2004) outlines the theoretical and methodological approaches in discourse analysis; Zeeman, Poggenpoel and Myburgh (2002) discusses discourse analysis as an approach to qualitative, reflexive nursing research; Campbell and Arnold (2004) offer a discussion on how discourse analyses may be applied to nursing inquiry; White (2004) outlines discourse analysis as a form of social constructionist inquiry for nursing research and Traynor (1996) sketches a commentary on discourse analysis.

There is also a growing body of research, which suggests this methodology has been usefully applied in a variety of practice settings including psychiatric nursing, midwifery, palliative care, learning disabilities, and forensic mental health care. Foucauldian discourse analyses are by far the most frequently occurring across the disciplines and some examples are offered here. Price and Cheek (1996) used a Foucauldian discourse analytic approach to explore the nursing role in pain management. Mohr (1999) used concepts from the work of Michel Foucault to deconstruct discourses in psychiatric nursing through examining the language used by nursing staff to describe patients in medical records. One of the most striking findings is that a large proportion of these entries emerged under the categories designated as pejorative, punitive, inane and nonsense. The language of professional jargon was evident in the content of these categories and functioned to obscure the clinical shortcomings of staff while simultaneously rendering them an air of authority. Mohr suggested that such charting speaks to the routinization and subsequent devaluation of important components of patient care - assessment and

evaluation.

Pryce (2000) used this same methodology in his exploration of the social construction of male sexualities in the fields of genitourinary practice as did Buus (2001) in his account of the changes in Danish psychiatric nursing between 1965-1975. Gilbert (2002) used this method in his analysis of the micro-politics of care planning in learning disabilities services. Riley and Manias (2002) used this approach to develop an understanding of how operating room nursing is constructed as a discipline and how operating room nurses act to govern and construct the specialty. More recently, Irving et.al, (2006) used this approach to explore the discursive practices in the documentation of patient assessment. The analysis found that biological descriptions dominated the content of these records and that there was little evidence of the contemporary nursing discourses of partnership, autonomy and self-determination.

Discourse analyses (other than Foucauldian) based on the works of a range of theorists are beginning to emerge in the nursing literature. For example, Horsfall and Cleary (2000) used a critical discourse analytic approach based on the work of Teun Van Dijk, a Dutch researcher to examine the special observations policy of an in-patient psychiatric unit to discern prevailing ideas about clients, nurses, doctors and their responsibilities and relationships. Their analysis suggests that the traditional medical hierarchy predominates in special observation with client rights, therapeutic processes and ethical dilemmas being significantly absent. Adams (2001) used elements of Silverman's conversational discourse analysis approach to explore the conversational and discursive processes that occur within domiciliary visits between community psychiatric nurses and relatives of chronically confused people. Three conversation formats were identified – interview format, the delivery format and the social interaction format - through which talk between community psychiatric nurses and carers is organised and accomplished.

Phillips, Fawns and Hayes (2002) used aspects of positioning theory (based on the work of Holloway and Harre and van Langenhove, 1999) to explore the dynamics of social episodes in professional midwifery learning. They suggest that reflection elaborated by positioning theory should be considered as the new epistemology for professional midwifery education. Li (2004) used a grounded theory approach and some of the analytic tools of conversation analysis to examine how palliative care nurses do criticism of other professionals in talk within settings for care of the dying.

Crowe and Luty (2005) offer a discourse analysis of the process of interpersonal psychotherapy in the recovery from depression. Although the report says the transcripts were conceptualised as texts following Fairclough's (1995) description of texts as social spaces, I could find little evidence of his theory of discourse analysis in this study. Kvarnstrom and Cedersund (2006) explored the discursive patterns in multiprofessional healthcare teams using a discursive approach based on the perspective of discursive psychology and described in the works of Potter and Wetherell (1987). These authors found that the linguistic constructs of "we" the team and "them" the patients predominated in the discourse of teams. We and all that it embodied (such as collegial trust and working together for the patients) were regarded as a pivotal construct in gaining and maintaining membership of this community. Skilbeck and Payne (2005) offer a discursive analysis of specialist palliative care nursing. However, the paper does not indicate which discourse analytic method was used and what the units of analysis were and these are difficult to determine in the reading.

Finally, a more detailed synopsis of one of the earlier discourse analytic studies in nursing is outlined. Heartfield's (1996) discourse analytic study of how nursing is constructed in case notes suggests that when contextually responsive research paradigms are brought to bear, a different kind of knowledge about the phenomena under study becomes visible. She used a synthesis of Foucault's

discursive analytic devices to explore six sets of hospitalized patient nursing case notes with a stay of longer than four days. The purpose of this study was to illuminate the discourses of nursing in these notes and to explore how these various discourses compete for visibility and in so struggling, constitute nursing.

Heartfield found that despite the large number of writings on the holistic and humanist characteristic of nursing and it's metaparadigms concepts (client, nurse, environment and health), these concepts were absent from the six nursing records. She argues that a body-part, cause-effect understanding of the client is manifest in these records and that this medicalised understanding works to communicate the performance of medical orders and medicalised client responses. She concluded that nursing caring as it is currently constructed is invisible work and that nurses are invisible in patient records.

2.4.4.1 Conclusion to other knowledges

These studies, based as they are on the analytic devices of different versions of social constructionism, provide an important counter-balance to the possibility of a specific model - rehabilitation, medical, interpersonal or otherwise - becoming entrenched as "truth" in psychiatric nursing discourse. It might be helpful for psychiatric nursing students to understand that psychiatric nursing theories and frameworks are creations of embodied persons within specific times, locations and institutional contexts rather than a-priori, a-contextual truths about the discipline. A social constructionist understanding might help to bring fresh ways of theorising about the interplay between how the subjects and doings of psychiatric nursing activity is constructed and the institutional, educational, and theoretical contexts within which these subjects and activities are situated.

2.5 Concluding remarks

This chapter has offered a comprehensive account of some of the more visible contexts framing this study. These were identified as the undergraduate problem-based nursing as praxis curriculum, the comprehensive but medically oriented contexts of the health sector, the psychiatric clinic and the person-centered field of psychiatric nursing knowledge. It was suggested that the kind of knowledge circulating within these contexts might influence the conversation doings of these texts, that is, of these student psychiatric nurse-psychiatric client episodes of clinic-based interaction.

This present study is developed around a social constructionist framework and uses nurse-client conversation as the resource for its study. I have had difficulty in sourcing studies in the field of psychiatric nursing that use evolving nurse-client conversation (and not recorded memories of it) as the site of study. This is not to suggest they do not exist and further searching might yield different results. It is therefore hoped that this study will contribute to the knowledge base of psychiatric nursing practice. The next chapter details the social constructionist, discourse analytic methodology for this study.

Chapter Three

Methodology

The Route, Adventures and Mishaps of the Process

3.1 Introduction

Epistemic diversity in qualitative research has the potential to excite and to paralyse (Georges, 2003; Tarlier, 2005). Terre Blanche and Durrheim (1999) distinguish between two broad traditions in qualitative research, namely the interpretive and social constructionist approaches. Although both traditions are concerned with meaning, the nature of the knowledge claims each aims to produce is different. Willig (2001, p.2-3) uses the two catchy terms "small question" and "big question" to differentiate between these two approaches. Whereas interpretation (small q) is concerned with the subjective understandings of individuals and groups, social constructionism (big q) is more interested in how such understandings are generated in, derived from and feed into instances of language in use and broader patterns of social meaning or discourse (Boutain, 1999; Fairclough, 1992; Georges, 2003; Terre Blanche and Durrheim, 1999).

This study has settled within the theoretical assumptions of the latter tradition and within the spirited approach to qualitative research forwarded by Silverman (2001) and Willig (2001). Silverman (2001) suggests that methodology in qualitative research lends itself to a lively explanation and discussion of the course of the decision-making while Willig suggests that qualitative research is "a...research-process-as-adventure" (2001, p. 2). The challenge for process-oriented, meaning-

generating "...big question" (Willig, pg. 3) qualitative research, is that there is no agreed upon doctrine for a qualitative methodology but rather, a series of methodologies with somewhat different ontological and epistemological orientations, all of which contribute to the methodology adventure (Georges, 2003; Phillips, 2001; Tarlier, 2005; Willig, 2001). Fontana (2004) argues that discourse and critical analytic studies work at the level of methodology and are defined through the way in which phenomena are approached and interpreted rather than through the method of data collection. Thus, contextual rather than technical decisions underpin big Q qualitative research (Fontana, 2004; Tarlier, 2005; Willig, 2001).

This is not to suggest that 'anything goes' in a discourse qualitative inquiry. Although I understand the research-process as adventure to offer possibilities for exploring phenomena in novel ways, I also understand this exploration to be grounded in the ideas of methodological rigour (Berman, Ford-Gilboe and Campbell, 1998; Carson, 2001; Tarlier, 2005; Tobin and Begley, 2004). If methodology is regarded as the defining feature of this kind of research then the methodology must be clearly articulated for the study to be evaluated. It is against this argument that the length of this methodology chapter is measured.

3.2 The research focus and route map

The study is positioned within the theoretical ambit of social constructionism. It uses the discourse analytic techniques of positioning theory to explore the discursive "doings" of student psychiatric nurse talk in the episodes of student nurse-psychiatric client interactions at the community-based psychiatric clinic (Silverman, 2001; Terre Blanche and Durrheim, 1999; Wetherell, 1998; Willig, 2001). The word "doing" is used here in the way of social constructionism to reference the action-orientation of discursive activity (Boutain, 1999; Fairclough, 1992; Potter and Wetherell, 1987; Silverman, 2001; Willig, 2001).

This chapter outlines the theoretical and methodological research-process-as-adventure route that the study follows. It gives a detailed, justificatory account of how various theoretical positions were integrated and developed as the methodology for this study. To this end, excerpts from these texts are used prior to the positioning analysis to illuminate this account of the methodology and how it was developed.

The chapter first sets out the theoretical assumptions of social constructionism in section 3.3. Although social constructionism does not subscribe to a specific theory of power, the constitutive perspective of this approach suggests that some kind of theorising about power may be necessary to articulate its possible workings (Gergen, 1999). To this end, post-structuralist ideas about the constitutive effects of social power are outlined in section 3.3.7 as one of the dimensions of social constructionism.

Section 3.4 turns to a description of the methodologies used for this study. In this section, I attempt to show how theoretical elements of discourse analysis, positioning theory and text structure descriptions were first identified as potential methodological devices and then integrated and illuminated as an aspect of methodological development for this study. To this end, positioning theory is first situated within the ambit of discourse analysis and thereafter, a precise description of its analytic devices is outlined. Although positioning theory suggests that a descriptive analysis of the speech and other features of the text may enrich a positioning analysis, it is not explicit about how this may be accomplished (van Langenhove and Harre, 1999). Therefore, a brief outline of the text structure analytic elements of Fairclough's (1992) three-dimensional theory of discourse that traverse this positioning analysis is given.

Section 3.5 provides a justificatory account of how the process of analysis unfolded through the discourse analytic methodology of generating texts, gaining entry into the texts and of developing a preliminary account of the effects of the texts

within the context of the research focus (Parker, 1992; Potter and Wetherell, 1987; Silverman, 2001; Willig, 2001). In this respect, section 3.5 is a first level analysis of the texts and this doing is as I understand, appropriate to a social constructionist discourse analytic approach (Potter and Wetherell, 1987; Willig, 2001). Section 3.5.1 shows how the texts were generated and transformed from talk into text using two transcription notation devices. Section 3.5.2 shows how Fairclough's text structure elements and post-structural ideas about power were used as a route of entry into the texts and to develop the basic discursive storyline "psychiatric surveillance" which is outlined in section 3.5.3 and then taken as the focus of the subsequent positioning theory analysis of chapter 4.

Finally, the chapter turns to a description of some of the pertinent issues inherent within the research-as-adventure process, namely the issues of methodological rigour, ethics and reflexivity.

3.3 Social constructionist assumptions of the study

The theoretical assumptions of social constructionism are informed by Gergen (1999) and Harre and van Langenhove's (1999) assertions that it is a broad term for an assortment of anti-empiricist positions in social and psychological theory. Social constructionism is increasingly being used to critique modernism and to inform theory generation in the social sciences in general (Gergen, 1999) and in nursing in particular (Berman, Ford-Gilboe and Campbell, 1998; Boutain, 1999; Georges, 2003; Hall, 1999; Phillips, 2001; Stevenson and Beech, 1998; Tarlier, 2005).

There are many versions of social constructionism, each of which emphasises the following working assumptions to a greater or lesser extent (Gergen, 1999; Harre and van Langenhove 1999). These working assumptions or entries into conversation are drawn from the idea that human experience, including perception, identity and

behaviour is generated in and reproduced through language (Gergen, 1999; Terre Blanche and Durrheim, 1999; Phillips, 2001; Willig, 2001).

3.3.1 A constitutive view of language

Social constructionism regards language as constitutive in that it actively constructs the particular objects and subjects of which it speaks (Parker, 1992). This perspective of language challenges the modernist assumption that language is a neutral and technical system for conveying commonly agreed-upon intentions and meanings in communication (Haber, 1994). Modernism sees language - words, grammars and structural properties of speech - as the a priori, neutral medium through which the "essence" of people, objects and experience are made visible and intelligible in dialogue (Boutain, 1999; Gergen, 1999; Hall, 1999). Social constructionism criticises this transcendentalist view of language and suggests that language rules and conventions are value-laden overt expressions of the normative order made immanent in concrete instances of language in use (Boutain, 1999; Georges, 2003; Davies and Harre, 1999).

Harre and van Langenhove (1999) argue that instances of language in use, that is, of speech acts or utterances are made intelligible in conversation through their social force. The social force of a speech act generally refers to the status of a communication or as Fairclough (1992) suggests to what is achieved in the saying of for example a promise, a greeting, a warning, an apology, or a description. The social force of a speech act is dialogically linked to the prevailing patterns of meaning circulating through the network of interactions situated within particular moral orders (Harre and van Langenhove, 1999). Thus, for example, the utterance "please be quite!" in the context of a lecture achieves its status in the way it is taken up by the various participants: as a request, a warning or a command. The social force of language – the joint development of interpersonal meaning - is further explored in section 3.3.4.

Most forms of social constructionism are concerned with unsettling and foregrounding speech utterances and text structure in their analyses. To this end, text analysis tools may be usefully applied to explore how, what is considered normative in a given context, are socially constructed and can be read, like a language, for their broader patterns of social meaning. Examples of text analysis tools are communication formats (Silverman, 1997), conceptual repertoires (Wetherell, 1998) and the analytical properties of text such as interactional control (Fairclough, 1992)

3.3.2 Discourse and language

Discourses – patterns of meaning in talk - are made visible in language. In its broadest sense and as it is understood in everyday language, discourse is defined as instances of language use in written, verbal and non-verbal speech (Fairclough, 1992; Silverman, 2001). In these instances, the terms "language" and "discourse" are used interchangeably (Fairclough, 1992).

However, the usage of the term in social and psychological theory extends beyond the spoken word to reference broad patterns of talk - or systems of knowledge statements - that are taken up in language in particular contexts, and which systematically construct the objects (and subjects) of which they speak (Georges, 1999; Parker, 1989; 1992, 1999; Terre Blanche and Durrheim, 1999). The term will be used in both ways in this study, that is, to indicate a stretch of psychiatric nurse-client talk, and where necessary, to refer to the broader patterns of meaning embedded within the talk.

In the main, the idea of discourse as a system of statements with constructive effects in specific contexts is derived from post-structuralism and specifically, from the French philosopher Foucault's writings about discourse (McHoul and Grace,

1993; Phillips, 2001; Smart, 1985). The usage of the term in Foucauldian post-structuralism is specifically directed towards the discursive practices and relations through which some groups of statements - and not others - achieve unity and meaning as a relatively well-bounded area of knowledge within a particular context (Smart, 1985).

Social constructionist writings and, amongst others, those of Gergen (1999) and Harre and van Langenhove (1999) use the post-structuralist idea of discourse to reference patterns of institutionalised meaning taken up in talk wherein social and psychological phenomena are made relatively determinate and knowable within particular contexts (Gergen, 1999; Macdonnell, 1986; Smart, 1985; Terre Blanche and Durrheim, 1999; Phillips, 2001; Potter, 2003).

Discursive practices refer to the various ways in which people actively construct and produce the objects (and subjects) of which they speak (Davies and Harre, 1999). Although the discursive practices in which social and psychological phenomena are identified as being constructed in talk might vary between theorists, the discursive practice of theorising begins with the idea of discourse (the meaning) and discursive practice (the doings) as constitutive. Stevenson and Beech (1998) suggest, in the way of Wittgenstein (in Stevenson and Beech, 1998), that "language and meaning are matters of use and doing in mutual action" (p. 791).

One of the criticisms of social constructionism is that everything has the potential to be discursive; for the purpose of this study, the discursive practice of subject positioning and the activities whereby they are jointly created in the student psychiatric nurse-psychiatric client episodes of interaction are fore-grounded.

3.3.3 Social and psychological phenomena are constructed in language and discourse

Social constructionism regards instances of language in use (spoken and semiotic forms) as both the substance of social reality and the resource for its study (Harre and van Langenhove, 1999; Parker, 1992). To this end, social constructionism criticises the positivist assumption that it is possible to know reality for what it is and suggests there may be many different versions of a particular phenomena - such as of identity and of psychiatric nursing knowledge - all of which are constructed in language between people in specific social, moral and historical contexts (Gergen, 1999; Harre and van Langenhove, 1999; Silverman, 2001; Terre Blanche and Durrheim, 1999). Ideas about the world, others and self (different forms of knowledge) are therefore regarded as the outcome of interaction rather than as the product of a rigorous and objective observation of the world by the individual mind (Gergen, 1999).

Further, social constructionism argues that ideas about the world, others and self (different forms of knowledge) are hierarchically constructed in the form of binary oppositions, such as 'good' and 'bad', 'normal' and 'abnormal', both parts of which are discursively available and made visible or invisible against the backdrop of the other (Gergen, 1999; Phillips and Drevdhl 2003). Thus, there is no fixed, central norm; what is perceived as an essential truth or way of being in a specific moral context can be understood as the visible part of the binary pair. How one end surfaces rather than the other in any given context is linked to questions of power, which are addressed in section 3.3.7.

3.3.4 Interpersonal meanings are generated in language in conditions of relationship

Social constructionism suggests that language, discourse and discursive practices are relational in that they derive their meaning from the ways they are used between people in conditions of relationship (Georges, 2003; Gergen, 1999; Stevenson and Beech, 1998). The idea that meaning jointly unfolds and develops in conversation is not to suggest that each interpersonal encounter is regarded as novel and that ways for "going on together" in the encounter must be developed, as if for the first time, for the interaction to be intelligible to the participants (Gergen, 1999; Harre and van Langenhove, 1999; Stevenson and Beech, 1998).

The intelligibility of interaction in conversation is derived from and prepared by a history of relationship or of co-ordination with others (Gergen, 1999; Harre and van Langenhove, 1999). Embedded within this history of relationship with others is each speaker's moral point of view. Point of view refers to both the speaker's position in time and space, as well as to his or her moral qualities and character, informed by a life-time of interpersonal interactions and moral constraints, rules and skills - including the ability to make moral judgements - about what people can say, do and are to themselves and to others, as specified within a particular cultural tradition (Gergen, 1999; Harre and van Langenhove, 1999). Thus, Gergen (1999) suggests that meaning in interaction is a property of coordinated points of view and joint actions, rather than of individual minds, actions and re-actions.

Although histories of relationship serve as a resource for managing present interactions, they are not deterministic (Harre and van Langenhove, 1999). Certain co-ordination of acts - such as for example the way in which the interactions in these texts are ritually ended through the medium of the next appointment - may be continuously enacted (Gergen, 1999). Ritual elements notwithstanding, the ongoing co-ordination of meaning in conversation provides an enormous range of

possibilities for words and actions to be co-ordinated in novel ways. Possibilities for co-ordination are evident in the ways in which social acts may be taken up or attended to by the participants in the conversation (Gergen, 1999; Harre, 1989).

For example, the nurse's speech action "how are you today, Mr Hlope?" becomes a candidate for meaning but is only given meaning through the ways in which Mr Hlope co-ordinates himself to it (Gergen, 1999). If Mr Hlope were to respond "I am fine", the nurse's speech act achieves its meaning as a speech action (greeting) through his supplemental actions. If on the other hand, he were to say, "I am in a hurry nurse, may I have my medication immediately", his urgency to leave re-casts the social meaning of the nurse's speech acts as "unnecessary for this situation". In both of these examples, the nurse's speech actions gain their meaning through the supplemental actions of Mr Hlope.

3.3.5 Patterns of social practice are generated and re-generated in dialogue

The social constructionist idea of social and psychological phenomena being constructed in dialogue situated in context, suggests that language and other forms of representation derive their meaning, not only from the ways they are used in relationships, but also from the broader patterns of social practice within which relationships are situated (Gergen, 1999). Broader patterns of discourse, such as for example, interpretive principles and practices underlying particular institutions, professional disciplines and different theoretical perspectives, are sustained through the ways in which they are made intelligible and sensible as practices in conditions of relationship (Gergen, 1999). The intelligibility of institutional practices is most often accomplished through specific forms of relationship and a shared language of description and interpretation which are generated and re-produced in conversation (Gergen, 1999; van Langenhove and Harre, 1999).

The intelligibility of institutional practice in shaping the objects and subjects of conversation is illustrated in Appendix B[6], Transcript 2, conversational cycles 2.1–2.4. Here medication is being jointly cast, not as one among other forms of management, but as the inviolable principle of psychiatric illness management. This principle is central to the intelligibility of biologic-diagnostic psychiatry as a framework for psychiatric services. For example, the benefits of psychiatric medication and other coping strategies in the management and reduction of psychiatric symptoms have been well established (Horwitz, 2002). This broader institutional principle and its corresponding practices are made visible in this instance of relationship where the psychiatric student nurse-talk has the effect of moving client talk about medication toward its helping effects and away from accounts which have the potential to suggest otherwise.

3.3.6 The self is a multiplicity of selves constructed and positioned in dialogue

Modern social theory locates the origin of thought, feeling, experience and knowledge within the individual self (Gergen, 1999). It assumes that individuals act as autonomous agents in their lives and that this capacity is derived from a unified, stable and essential self (Haber, 1994). Although people assume specific social roles, these roles are seen as exterior to the real self, worn and removed as the situation demands (Hardin, 2001). Constructionism (to varying degrees) regards the self as an effect of instances of language in use and therefore, as heterogeneous and as versatile as language itself (Haber, 1994). It therefore supports the idea of a de-centred self (Haber, 1994), of a non-essential self (Parker, 1992), of selfhood (Harre and van Langenhove, 1999), of an assembled self (Rose, 1997) and of self as a "territory of language" (Haber, 1994). There are thus, different accounts of the de-centred self

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[6] The use of excerpts from these texts was declared as a convention to illuminate the methodology in section 3.2.

within social constructionism (Haber, 1994) and therefore, the understanding of self as selfhood, subject positioning and agency constructed in conversation and used in this study, will be briefly outlined.

3.3.6.1 Selfhood constructed in dialogue

Harre and van Langenhove (1999) use the term selfhood to signify two kinds of identity, the personal and the public. The first is the self of personal identity, which is experienced as the continuity of the person's relationship history and other socially and culturally mediated qualities, within and across time and space. Personal identity is experienced and expressed through the use of discursive devices such as the terms "I" and "me" which flag people's utterances as belonging to the singular self of personal identity. In this sense, the personal self is a psychological reference point in time and space that backgrounds the public identity, rather than a set of specific structural psychological characteristics and conditions (Davies and Harre, 1999).

The second kind of selfhood is the multiplicity of public personas - a coherent cluster of traits - that are manifest in the speaking in everyday life. Thus, while there is singularity in the personal identity of selfhood, there is a multiplicity of personas with different clusters of behaviours that emerge within specific conversational contexts and which are given voice. Personas are presented discursively and to the extent that they are recognised and confirmed as specific person-types by others, are jointly constructed (Davies and Harre, 1999). A constructionist perspective of the self as relational and jointly constructed is not to imply that a sense of self within a particular instance is not possible but rather, that dialogue creates spaces or positions for various types of personas within a given moral order of speaking (Parker, 1992).

3.3.6.2 Subject positions constructed in dialogue

Dialogue creates parts or positions for people to discursively occupy within a moral order of speaking which once taken up locates the speakers as standing in various kinds of polar moral relations in the jointly developing dialogue (Davies and Harre, 1999). Technically, a position is defined by a certain set of rights, duties and obligations as speaker. Positioning is defined as "...the discursive construction of personal stories that make a person's actions intelligible and relatively determinate as social acts and within which the members of the conversation have specific locations"(van Langenhove and Harre, 1999 P. 16.)

Mills (1997) suggests that the authority and right to speak from a particular position has to be established for a subject position to be "called" into practice. She and others suggest that the rights, authority and obligations to speak from particular positions may be differentially distributed and manifest in dialogue through the complex weaving together of moral imperatives within a given context. These imperatives include the rules, the rights to authority and the conventions and social practices of the conversational context and the various forms of knowledge (of self, other and ways of going on together) being constructed or marginalised in dialogue (Mills, 1997; Moghaddam, 1999).

For example, within the storyline of medication as the inviolable principle of psychiatric illness management referred to in section 3.3.5, the nurse and client are positioned as standing in relations of psychiatric expert and psychiatric novice. Within this storyline, the nurse is positioned and appears in the persona of the arbiter of diagnostic psychiatry, authorised to use its expert psychiatric knowledge base in her speaking to discursively shape the client's account of medication in the direction of the storyline. The client on the other hand is positioned and appears within the storyline in the persona of a psychiatric novice, authorised to speak in this voice and not any other. Any attempt the client might make to authorise his own

account of his experience of medication is constrained, rather than enabled, through these various acts of discursive positioning.

This is not to suggest that people are acted upon by positioning in different moral contexts. Social constructionism regards subject positioning as a process through which speaking positions and the right to speak, and with what voice, are progressively and dynamically, if somewhat unequally, achieved (Gergen, 1999; Parker, 1992). The ideas that subject positions (including the authority to speak in a particular way) work to enable and/or to constrain specific actions within the developing storyline suggest they are linked to questions of agency and of power (Boutain, 1999; Mills, 1997; Moghaddam, 1999).

3.3.6.3 Agency and self-authorisation

Modern social theory regards the individual's capacity for directed social action and autonomy in social life as a corollary of the rational, independent, productive, choosing and essential self (Haber, 1994). Thus, the capacity for agency - the will, motivation and the ability to act in a self-determined manner - is seen as both a structural property and effect of the unified self (Shotter, 1989).

Social constructionism on the other hand, proposes that agency and associated processes of the self such as "will" and "motivation" is carried in the discourses of self-awareness, self-command and self-evaluation and is made immanent in the indexical grammars of self-ascription such as "I" and "me" (Harre, 1989). Shotter suggests that the meanings inhered in these forms of self-ascription are not derived from any intrinsic knowledge of the essential presence of the states themselves, but from the ways in which they are used in language, in conditions of relationship and within the broader moral context (Shotter, 1989). Thus while modern social theory locates the capacity for agency within an ethic of individualism, social constructionism locates it within an ethic of community (Shotter, 1989).

While agency may be evident in the grammars of self-ascription, it is made intelligible as ways of doing and showing self in conditions of relationship and community (Shotter, 1989). From this perspective, agency is conceptualised not as an intrinsic set of properties but as a cluster of concepts that describe the sort of thing people do in conditions of relationship, to merit the characterisation of agency (Harre, 1989).

Harre regards accounts of self-authorisation in conversation as the "criterial doing" for the characterisation of agency (1989, pp. 31). He describes three distinct ways in which self-authorisation is accomplished in doing agency in interaction (Harre, 1989). The first is through referring to one's powers and one's rights to exercise them, the second is through referring to aspects or events in one's biography (reporting on what I did, saw, felt and what happened) and the third is through referring to personal experiences as legitimising certain claims and actions (Harre, 1989).

The term doing agency is therefore applied in instances of interaction where particular kinds of accounts are offered in which the person's reason or reasons for acting are openly displayed to another or to self, and justified by reference to self-authorisation (Harre 1989). Further, and this is an important point to be made in the analysis, the extent to which acts of self-authorisation are manifest as intelligible acts of agency are dialogically linked to the extent to which they are taken up and sustained as such by both speakers (Gergen, 1999).

For example, the client in the following illustration from Transcript 6 (Appendix F lines 17-22) [7] may be said to be "doing agency" when he draws upon an event in his personal biography *"a:: (.) as a (.) matter of fact uh::: I believe I am a stable person (.5) and I should be taken off ((laughs))"* to authorise his assessment of himself as stable in response to the nurse's inquiry about the effects of his medication.

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[7] An explanation of the transcription notations may be found in section 3.5.1.3.

However, the extent to which his assessment of himself is manifest as an intelligible act of agency is dialogically linked to his self-depreciating *(laugh))* at the end of his utterance, to the nurse's supplemental speech act *"Ja:::: (.5) so you're okay with this medication"* and to his subsequent agreement response *Ja"*. His utterances together with those of the nurse, simultaneously blocks the uptake of his act of self-authorisation as an act of agency and reformats it as a jointly constructed account of psychiatric/medication assessment.

This example highlights not only the relational character of agency but also the ways in which it may be asymmetrically manifest or obscured as an act of agency within the particular moral order of speaking (Shotter, 1989). In this example, the client and the nurse are jointly called to account for the client's act of self-authorisation from within the perspective of the psychiatric moral order, that is, to develop an account that corresponds with the institutional principles and practices of the psychiatric clinic. Gergen (1999) suggests that this kind of moral order calling to account - of interpellating - is necessary, not only for the client's account of self to be intelligible within the context of the interpersonal encounter and the psychiatric moral order, but also for the intelligibility of the moral order within the broader social context of, in this case, of contemporary understandings of health care.

3.3.6.4 Conclusion

Agency, like selfhood, subject positioning and understanding or knowledge making, are discursive threads woven from and weaving into the prevailing broader social discourses and practices circulating through episodes of interaction in a given social context. Social constructionism also suggests that the sites at which these threads intersect, that is, within conditions of relationship, are the sites at which some forms of ways of doing, being and knowing are legitimised, and others marginalised (Davies and Harre, 1999; Phillips and Drevdahl 2003).

Post-structuralist ideas of the relation between knowing and power are discussed in the following sections and go someway to explaining how some forms of being, knowing and doing are manifest as truth and others not, in conditions of relationship situated within the broader social context (Adams, 2001; Browne, 2001; Dreyfus and Rabinow, 1982; Haber, 1994; Kushner and Morrow, 2003; Mills, 1997; Phillips and Drevdahl, 2003; Phillips, Fawns and Hayes, 2002).

3.3.7 Social constructionism and social power

Social constructionism does not subscribe to a specific model or theory of power and this is entirely consistent with its non-essentialist standpoint (Haber, 1994). However, the constitutive perspective of language suggests that some kind of theorising about power is necessary provided the analysis itself is seen as one possible version of how power might work in conditions of relationship (Gergen, 1999). Gergen (1999) highlights the inadequacy of the modern, dominant-repressive thesis of power for social constructionist theorising. He suggests that while a structural perspective of power is a rich resource for social action, it obscures the ways in which power is insinuated into the ordinary of everyday life (Gergen, 1999). Post-structuralism therefore focuses its analysis on the ways in which power is exercised over and functions through everyday life (Haber, 1994). A number of interrelated ideas about the power/knowledge network are outlined in the following section, but only to the extent that they will be used to inform the subsequent analysis.

3.3.7.1 A constitutive view of knowledge/power and its effects

Social constructionism sees power as a multiplicity of enabling and restraining relational forces circulating in and through language in social contexts, working to generate, to stabilise and to normalise particular forms of knowledge about social

and psychological realities as right or true while simultaneously marginalising other forms (Gergen, 1999; Gilbert, 2002; Haber, 1994; McHoul and Grace, 1993; Mills, 1997; Parker, 1992; Smart, 1985). Post-structuralism suggests that the sites at which social and psychological realities as forms of knowledge are made immanent (or marginalized) in conditions of relationship, are also the sites at which power is manifest and exercised (Gergen, 1999; Hall, 1999; Haber, 1994).

Foucault first referred to the overlapping and interweaving of power and knowledge as power/knowledge (Smart, 1985). Language and discourse is regarded as a form of knowledge/power because it carries within it authoritative ways of describing - definitions, categories, explanations, sayings, doings and meanings - that simultaneously produce and regulate what it describes (Gergen, 1999; Gilbert, 2002; Phillips and Drevdahl, 2003).

3.3.7.2 Techniques of disciplinary power/knowledge practices

Post-structuralism suggests that power is intelligible, not as a singular social force but in terms of the techniques and methods through which relations of knowledge/power is produced and reproduced in moral orders of speaking and disciplinary spaces (Adams, 2001; Gilbert, 2002; Hardin, 2001; McHoul and Grace, 1993). Disciplinary power operates through specific techniques of surveillance or hierarchal observation, normalising judgement and the examination and the confessional (Dreyfus and Rabinow, 1982).

These techniques offer procedures for training, shaping, moulding and/or coercing a return to the norm in individuals and groups linked to particular forms of identity and located within specific disciplinary spaces (Smart, 1985; Dreyfus and Rabinow, 1982). The effect of these disciplinary techniques is the production of compliant, obedient and useful individuals (Dreyfus and Rabinow, 1982; McHoul and Grace, 1993). These techniques will be outlined in some detail because they will

be used to inform aspects of this study's positioning analysis and subsequent social constructionist theorising.

3.3.7.2.1 Hierarchical observation

Hierarchical observation references a permanent, on-going and asymmetrical surveillance or looking down-over those positioned within the ambit of a particular disciplinary gaze and in the case of this study, of the student psychiatric nurse community-based clinic gaze (Gilbert, 2002; McHoul and Grace, 1993). The effects of the disciplinary gaze are that its subjects are individualised and highlighted within their respective functional positions (for example, nurse and client) and then subjected to increased authority through normative restrictions on their individual or visible behaviour (Adams, 2001; Smart, 1985).

Foucault suggests that the awareness of being continuously observed effectively ensures an automatic and efficient functioning of power (Smart, 1985). To this end, those who believe they are in a constant state of surveillance internalise the act of surveillance and impose normative behaviours upon themselves and in so doing, act in response to themselves as agents of the disciplinary gaze (Holmes, 2001). The disciplinary gaze articulates the connection between visibility and power and particularly, that observation, often conceptualised as a neutral activity, induces effects of power through the way it illuminates, regulates and modifies difference (Holmes, 2001; Smart, 1985).

Holmes (2001) argues that modern forms of surveillance (observation, information gathering, normative analysis, behavioural change and on-going monitoring and evaluation) and self-surveillance (such as reflection) are integral to contemporary psychiatric nursing practice. This is not to imply that surveillance is a pejorative or positive psychiatric nursing activity with pejorative or positive effects

but rather, that it induces effects of power – particular ways of knowing, doing and being and not others – for those caught up within its gaze (Mills, 1997; Gilbert, 2002).

3.3.7.2.2 Normalising judgement

The second technique of disciplinary power is the normalising judgement. The normalising judgement is a standard or series of standards for personal and functional evaluation applied within the particular disciplinary space (Smart, 1985). The possibility for the presence of a standard or norm in the first place, is drawn from the democratic ideal of formal and structural equality among all people (Dreyfus and Rabinow, 1982). Foucault (in Smart, 1985) characterises normalising judgement as a micro-penalty, exercised where necessary and over a wide range of social and personal behaviours which have been measured, ranked and found wanting with respect to their degree of correspondence with the norm.

Smart (following Foucault, in Smart, 1985) suggests that modern disciplinary power subjects people to a range of micro-penalties of time, of activity, of behaviour and of speech in order to correct and to redress abnormal or out of the ordinary behaviour. Thus, for example, a normalising judgement with respect to behaviour might be applied when a client's affect is judged to be inappropriate for the context (Dreyfus and Rabinow, 1982).

These normalising judgements work through punishment as well as through gratification. For example, medication-compliance is a normative standard for healthy psychiatric behaviour in psychiatry. Clients who meet this norm might be rewarded (for example, with approval from the nurse and doctor) while those who don't may have certain sanctions imposed upon them, such as the replacement of oral medication with a fortnightly injection that has implications for how closely their behaviour will be monitored. This example illustrates an important point about normalising judgement. The function of normalising judgements is normalisation - to

return behaviours to the norms of the particular disciplinary space - and not punitive acts of repression or malicious intent. (Dreyfus and Rabinow, 1982; McHoul and Grace, 1993; Smart, 1985).

3.3.7.2.3 The examination and the confessional

The ritual of the examination and/or the confessional combines the techniques of hierarchical observation and the normalising judgement. Fairclough links the examination and confession to particular forms and practices of knowledge/power (1992). He proposes (following Foucault) that the examination is associated with normative assessment, measurement and classification while confession is associated with particular forms of pastoral knowledge/power relations where talking about the self in relation to some norm, is the focus. Psychiatric assessment and diagnosis is an example of the former and religious confession and the varieties of therapeutic counselling examples of the latter (Fairclough, 1992).

The examination

The examination may occur in clinics, hospitals, schools and universities or in any organization or institution where disciplinary power is evoked. Smart (1985) suggests that the effect of the examination as a site of disciplinary power/knowledge is accomplished in two significant ways. In the first place, the techniques of observation and normalising judgement combine to bring about a normalising gaze in which individual attributes are highlighted, analysed, classified and judged (Holmes, 2001). In this respect, a particular kind of knowledge about the individual as a case or a set of re-constituted parts (biological, psychological, social, emotional, cognitive and so on) is being evoked and inscribed.

A second effect of the examination is the extent to which its normalising gaze constantly highlights and fixes the objects of its interest in the field of writing

(Dreyfus and Rabinow, 1982; Smart, 1985). Minute observations of the person are encoded as particular attributes within written reports and files (Smart, 1985). These methods of documentation have the potential to be organised into large-scale classificatory, surveillance registers and instruments of normalising intervention such as for example, the diagnostic and statistical manual of mental disorders and the nursing diagnosis and care planning systems (Crowe, 2000 and 2006; Horwitz, 2002).

The confessional

Finally, whereas discipline works to objectify subjects, confession works to subjectify objects, that is, to locate the problems being experienced by the person within the domain of the personal rather than the social (Hook, 2000). Confession is defined first with reference to its topic, that is, the speaking subject who is the subject of the confession or telling, and then with reference to the power relationship between those involved. Fairclough (1992) suggests that the tendency for humans to hollow out and to talk about themselves in an ever-widening set of social locations may seem a liberating resistance to the objectifying power of discipline. However, the act of confession within a particular disciplinary space requires the presence of a person authorised to prescribe the telling, to receive it, to validate it, to judge it and to intervene to release the person from the weight of the burden (Fairclough, 1992).

Thus, while the act of confession changes the person who does it, it simultaneously draws the person further into the prevailing power/knowledge relations of the disciplinary space and hence, within the ambit of the normalising effects of power/knowledge (Fairclough, 1992).

3.3.7.3 Social power and transformation

The implication of a relational, enabling-restraining perspective of power with

norm-inducing effects is that it is a source and resource and not only for the exercise of power but also for the simultaneous exercise of resistance and confrontation in conditions of relationship (Holmes, 2001; Phillips and Drevdahl, 2003; Pryce, 2000). Gergen (1999) suggests (following Foucault) that power and resistance are synonymous with social life in that every form of knowledge/power relation implies a potential strategy of resistance against the practices of power.

Post-structuralism proposes that where action exists within a field of possibilities (and psychiatric nursing discourse is a field of possibility) it is possible for the free play of the forces of resistance and struggle to undermine the stable mechanisms through which behaviour is ordered and regulated (Mills, 1997; Smart, 1985). Post-structuralism does not offer a list of potential strategies of resistance but rather, suggests that what ever is aimed at illuminating, destabilising and / or subverting the normalising and regulating effects of power over peoples' bodies and lives, is a form of resistance (Smart, 1985). For example, the client's retreat to monosyllabic responses to the nurse's questions about his medication in Transcript 6 (Appendix F) lines 23-30, may be seen as a form of resistance to the discounting and docile-inducing effect of the nurse's by-passing his attempt at self-authorisation in lines 17-20.

3.3.7.4 A brief dialogue with the potential limits of post-structural power for social constructionist theorising

Fairclough (1992) and others (for example, Haber, 1994 and Macdonnell, 1986) suggest that one (among others) of the major limitations of Foucault's understanding of power is that it fails to account for the economic, racial and gender disparities in social power. While this may be the case, Macdonnell (1986) does suggest that a post-structuralist conception of power is potentially transformative. She argues that a post-structural analysis that illuminates how forms of power/knowledge are

constituted in their struggle for visibility and prominence at various localised sites (for example, in relations between men and women in particular contexts) simultaneously illuminates strategies for struggle and resistance (Macdonnell, 1986).

Gergen (1999) argues for a social constructionist analysis of the `how' rather than `why' of power/knowledge in order that instances of resistance to it are seen not as opportunities for subversion or coercion, but as opportunities for transformation and change. Thus, transformation is seen as one of the outcomes of the exercise of power/knowledge and in so seeing, underscores the productive nature of power. It is this aspect of power/knowledge/resistance relations with which this study and subsequent theorising, is concerned.

3.3.8 Conclusion to the theoretical assumptions of the study

This section has accounted for some of the theoretical assumptions of social constructionism that inform the positioning theory discourse analytic methodology of this study and which are outlined below.

3.4 The methodologies of analysis

The terms discourse and discourse analysis are common currency in a variety of social constructionist and post-structuralist writings (Mills, 1997). I would like very briefly, to situate positioning theory within the ambit of discourse analysis (as it is used in this study) before going on to highlight its theoretical principles and to describe its analytic methods. I think this is necessary because of the diversity of approaches that seem to fall within the remit of discourse analysis (Mills, 1997; Potter and Wetherell, 1987).

3.4.1 Discourse analysis

The social constructionist perspective of discourse (see section 3.3.2) highlights three of its main elements that are simultaneously the focus of discourse analysis (Horsfall and Cleary, 2000; Terre Blanche and Durrheim, 1999). Terre Blanche and Durrheim (1999) define discourse analysis, as ways of studying how particular patterns of meaning in talk are deployed to achieve particular effects in specific contexts. Thus, the elements of discourse (patterns), effects (action-orientation of the texts) and context constitute an understanding of the term discourse and of the activity of discourse analysis.

Various forms of discourse analysis emphasise different aspects and different configurations of these aspects – pattern, effect and context - in their analysis (Terre Blanche and Durrheim, 1999). Discourse analysis is therefore an umbrella term that refers to a multitude of approaches with diverse theoretical and methodological orientations (Horsfall and Cleary, 2000). To this end, a rough distinction is sometimes drawn between two different versions of discourse analysis in the social sciences, that is, between discourse or discursive analysis (DA) and Foucauldian and critical discourse analysis (CDA) (Silverman, 2001; Willig, 2001). The following paragraphs highlight some of the crude differences between these two forms. In general, the criticism each form has of the other revolves around the degree of attention to text and to the broader social context (Titscher, Meyer, Wodak and Vetter, 2000; Van Dijk, 1997).

Discourse analysis (sometimes referred to as discursive psychology) has its roots in sociology, psychology and ethnomethodology and conversation analysis and is concerned with developing a fine-grained analysis of the ways in which participants jointly construct and negotiate meaning in talk (Silverman, 2001; Wetherell, 1998; Willig, 2001). In this respect, the various ways in which a speaker's actions in talk (for example, turn-taking, greetings and disagreements) are shaped by

the context of the preceding sequence of talk are its primary objects of analysis (Willig, 2001). Some forms of discursive analysis such as conversation analysis, use what the approach suggests are relatively stable characterisations of language structure, to explore how participants uses these same structures to negotiate meaning in talk within the text (Fairclough, 1992; Schegloff, 1997; 1999; Silverman, 2001; Willig, 2001). The interaction is therefore regarded as both the element of analysis and the context within which the talk is explored. Broader patterns of social practice (such as for example, social power relations between nurses and clients) are attended to, but only to the extent that they are manifest in talk by the participants themselves (Schegloff, 1997; 1999; Silverman, 2001).

Critical discourse analysis on the other hand extends its vision beyond the level of the text to take account of the text and the broader social practices within which the text is situated (Willig, 2001). Critical discourse analysis has its roots in philosophy and specifically, in the post-structuralist knowledge/power ideas, some of which were outlined in the previous section 3.3.7 (Georges, 2003; Willig, 2001). In the main, this approach explores the dialogical relationship between patterns of talk and the broader social context wherein ways of saying and doing are simultaneously reproduced and re-inscribed as culturally dominant practices with implications for subjectivity, selfhood and agency (Fairclough, 1992; Horsfall and Cleary, 2000; Potter and Wetherell, 1987; Willig, 2001). The term critical refers to multiple perspectives that may differ on the text, meaning and context dimensions but share as a goal the generation of knowledge, which contributes to transformation and change (Georges, 2003). Boutain (1999) and Kushner and Morrow, (2003) suggest that CDA is a contemporary methodology for a nursing inquiry concerned with issues of power and transformation in the discipline of nursing.

The constitutive perspective of language underpinning social constructionism and this study would suggest that the distinctions between DA and CDA are not rhetorically neutral and are useful only to the extent that they illuminate different

possibilities for discourse analysis within the field of possibilities that is discourse analysis (Billig and Schlegoff, 1999). Whereas DA criticises CDA for their sometimes-sloppy attention to the features of text and their a-priori stance on the relations between text and broader social practices, CDA criticises DA for its inadequate attention to broader social practices and its a-priori stance on the meaning-generating features of text (Titscher, Meyer, Wodak and Vetter, 2000; Van Dijk, 1997; 1998).

3.4.2 Discourse analysis as a field of possibilities for a social constructionist inquiry

Arguments for and theories of an inclusive approach to discourse analysis in health science have been forwarded, all of which to some extent, highlight facets of the text-effect-context interface for the construction of identity, selfhood and agency in conditions of relationship situated within specific moral contexts (Boutain, 1999; Crowe, 2000; Harre and van Langenhove, 1999; Parker, 1992; Wetherell 1998; Willig, 2001).

Parker (1992) and Wetherell (1998) for example, argue for a synthetic approach that focuses upon the development of analytic devices – such as positioning, conceptual repertoires and social schemata - which work across the intellectual domains of discursive analysis and critical discourse analysis. Wetherell (1998) proposes that such an eclectic approach would allow researchers to explore the relations between the textual features of talk, discursive practices, the wider institutional context and their effect on the socio-cognitive processes of subjectivity, identity and selfhood (Wetherell, 1998). Parker (1992) argues that a discursive analysis may be considered incomplete if it does not offer some account of the relations of discourse, identity and power and to this end, he draws quite heavily on critical theory to inform his understanding of discourse analysis (Parker, 1992).

Willig (2001) suggests that one of the potential outcomes of an inclusive analysis is the development of a variety of different insights about the social and psychological phenomena under study, which either version on its own would not have been able to generate. The idea of inclusivity for this study is pursued in the next section.

3.4.3 Positioning theory as one possibility in the field of discourse analysis possibilities

3.4.3.1 Introduction

The idea of a synthetic discourse analytic approach that is of language, effect and immediate and broader context is very much the substance of Harre and van Langenhove's (1999) theory of positioning. The theory suggests that the flow of everyday life is fragmented through discourse (broad patterns of social meaning[8]) into distinct episodes of interaction that constitute the necessary elements of both individual biographies and the social world (Harre and van Langenhove, 1999). To this end, positioning theory sees conversation and conversation-like activities as both the substance of the social world[9] and the resource for its study.

van Langenhove and Harre argue that an analysis of conversation and conversation-like activities needs to be undertaken from within the context of a person/acts referential grid, rather than from within the a-priori-space-time grid of the natural world (1999). While the latter referential grid uses a set of relatively stable concepts such as "role" and "gender" to account for specific social acts, the proposed

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[8] See section 3.3.2 – 3.3.5 for a review of discourse as the interplay of intrapersonal, interpersonal and broad social patterns of meaning.

[9] Defined here as ..."a network of interactions framed within some relatively stable repertoire of rules and meanings." (Harre and van Langenhove, 1999, p. 11.)

grid sees people in conversation as shifting locations for the study of the social world (Harre and van Langenhove, 1999).

Positioning theory therefore focuses its analytic gaze on episodes of intrapersonal, interpersonal or inter-group interaction in an effort to understand how social and psychological realities– such as identity, patterns of knowing and selfhood - are constructed and re-produced in these distinct episodes situated within specific moral and disciplinary spaces (Harre and van Langenhove, 1999). Sabat suggests that any one of these dialogical sites may be the starting point for a positioning inquiry and that a particular focus is a matter of theoretical choice rather than of any particular truth about the social world (Sabat and Harre, 1999). This theory's emphasis on the doings of conversation fits nicely with the interactional stance of modern psychiatric nursing theory that regards the nurse-client relationship as the primary doing of psychiatric nursing practice (Crowe 2000; Horsfall and Cleary, 2000; Gergen, 1999).

3.4.3.2 The positioning triangle

Positioning theory and its analytic devices are drawn from an understanding of the dynamic interplay and effects of three mutually determining features of conversation namely, subject positioning, speech acts-actions and storylines (van Langenhove and Harre, 1999). The authors argue that conversational utterances unfold along storylines (progressively developed braided patterns of social meaning) and manifest as meaningful social actions through the various ways in which speakers are positioned and position themselves in dialogue situated in a particular moral order of speaking (Davies and Harre, 1999).

The authors further suggest that this mutually determining, tri-polar perspective of conversation provides for enormous variation in interpersonal positioning across individuals. Individuals may differ in the extent to which they

have or are able to acquire the necessary skills and competencies for intentional positioning and in their willingness to position or to be positioned within a given storyline (Davies and Harre, 1999). Individuals may also differ in their capacity to accomplish positioning acts within specific locations because the authority for moral positioning may be differentially distributed within the formal or informal moral order of speaking (Gergen, 1999). These differences highlight the shifting social and personal dimensions of interpersonal positioning (Davies and Harre, 1999).

For example, the illustration in 3.3.6.2 (and 3.3.5) showed how the nurse and client were first positioned by the moral order of the clinic as standing in relations of novice and expert with differential authority to speak within the psychiatric storyline. However, there are many examples in the texts where these positions are destabilised within the psychiatric storyline, which suggests that other configurations of access to the rights of positioning, such as the basic skills of argument, negotiation and individual particularities may also be at work (Davies and Harre, 1999; Gergen, 1999).

Positioning is therefore understood as a range of discursive practices for making particular psychological and social phenomena determinate as social actions in instances of social interaction, situated within moral orders of speaking (Harre and van Langenhove, 1999). These practices are outlined below.

3.4.3.3 Positioning practices

Positioning practices represent a synthesis of the various ways of positioning which characterise them as practice types (Harre and van Langenhove, 1999). These ways of positioning are analytical distinctions found within the network of intentional/unintentional; self/other; and deliberate/forced positioning, and which manifest in the three practice types of first, second and third order positioning practices (Harre and van Langenhove, 1999).

3.4.3.3.1 Unintentional first order positioning practices

First order positioning practices refer to the various ways in which speakers position themselves and others within the on-going conversation using various moral binaries (right/wrong, professional/unprofessional) and storylines. First order positioning actions are generally accomplished without question, negotiation, or dispute. In this respect, first order positioning practices are usually unintentional, unconscious or implied and have immediate action or performative effects. First order positioning practices are an essential feature of ritual and of commonly agreed upon disciplinary and social practices (Gergen, 1999; van Langenhove and Harre, 1999).

For example, it may be common practice in a particular clinic for psychiatric nursing students to do all the admission interviews. A request from the sister to this effect would have an immediate effect in that the interview either would or would not be done. By way of further illustration, I would suggest that almost all (if not all) of the episodes of interaction in Transcript 3, Appendix C are examples of first order positioning-talk. There is a smooth, ordered and struggle-free tone to the interactions wherein the moral positions of questioning nurse and reporting client are highlighted and taken for granted within the unfolding storyline of the psychiatric clinic.

3.4.3.3.2 Intentional second order and third order positioning practices

First order positioning acts appear seamless because they are immediately intelligible as actions through their performative effects. Second order positioning acts-actions on the other hand, are accomplished through the various ways in which first order positioning practices are negotiated and accepted or rejected within the on-going storyline (van Langenhove and Harre, 1999). First order positioning

practices can be queried within the on-going storyline through second or third order positioning practices (van Langenhove and Harre, 1999). The difference between second and third order positioning practices is their discursive proximity to the original conversation. Queries made and manifest as social actions within the evolving conversation are second order positioning practices whereas queries made within another conversation about the original conversation are third order practices. Gossip is regarded as a third order practice.

Second order positioning practices are intentional formulations with accountive effects (Fairclough, 1992; van Langenhove and Harre, 1999). For example, I suggested in the illustration in 3.3.6.2 that the first order positions of novice and expert are immediately available in the psychiatric storyline. Although these positions were taken up without negotiation in Transcript Two (Appendix B), there are also many textual examples where these positions are disputed. The degree of visibility of second order positioning actions in conversation is dialogically linked to the extent to which first order positioning acts-actions are jointly taken up and talked about within the evolving storyline (Gergen, 1999).

van Langenhove and Harre (1999) describe four distinctive forms of intentional, second order positioning which may manifest (singularly or in concert) in episodes of interaction as distinctive intentional positioning practices. These practices include instances of deliberate self-positioning and forced self-positioning and instances of deliberate and forced positioning of others.

Deliberate self-positioning

This usually occurs in pursuit of particular interpersonal objectives and is manifest in the grammars of self -ascription[10]. People may deliberately position themselves by emphasising agency, by referring to their histories of relationships as a

[10] See section 3.3.6.3 for a review of this process.

means to detail their unique point of view or by referring to events in their personal biography as a way of legitimising the assumed position (Harre, 1989).

Forced self-positioning

Whereas the initiative for deliberate-self positioning is located within the individual, the initiative for **forced self-positioning** lies with an outside other - person or institution that has the moral authority to call specific positions into action within its disciplinary space. The effects of forced self-positioning may range from mild to coercive, depending from whence the demand for positioning comes. For example, within the context of these texts, a simple greeting from the nurse "how have you been this month Mr X?" requires Mr X to position himself as psychiatric client in order for the interaction to have intelligibility as a monthly psychiatric clinic interview. This form of positioning is forced but hardly coercive.

However, forced self-positioning may manifest in more pressing forms in institutional episodes of interaction where designated persons have the authority to make moral judgements about people within its' moral space, and then to call them to account for their actions from the perspective of the institution's principles and practices. Being called to account (to interpret and to explain) for social actions from an outside perspective has a coercive overtone because the participants are forced to position themselves as agents within the storyline in order to develop a coherent and intelligible account[11] (Davies and Harre 1999.).

For example, the psychiatric atmosphere of the nurses speech actions in these texts imply they are responding to the call of the institution to position themselves as authorial agents in the unfolding psychiatric storyline. Conversely, the psychiatric

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[11] See section 3.3.5 for a brief description of the interpellated subject.

symptom reporting speech actions of the clients suggest they too have responded to the call of the institution's delegated authority to account for their well being in psychiatric, rather than any other terms. Thus, both participants are forced to position themselves and each other in particular ways in order for the interaction to be intelligible in the institutional context. This kind of forced self-positioning has particular implications for how the nurse-client participants go on together in these specific conditions of relationship and the extent to which other patterns of knowledge and practice are available as discursive resources for them to draw upon (Gergen, 1999).

Deliberate and forced other-positioning

These may occur in the presence or absence of the person being positioned. Deliberate and forced other-positioning in the presence of the person being positioned creates a particular kind of place in the speaker's storyline which the other may feel obliged or even coerced to take up or to resist (Davies and Harre, 1999). Deliberate other-positioning is evident in transcript 6, Appendix F lines 11-42 where the nurse reframes the client's attempts at self-authorisation as the outcome of effective medication management thereby creating a compliant space in the psychiatric storyline for the client to take up.

3.4.3.4 The positioning triangle emphasis in this study

Positioning is understood as a dynamic practice wherein the interplay of storyline-acts-actions-positions is constantly being transformed through conversation and constantly works to transform the unfolding conversation situated within particular contexts (Harre and van Langenhove, 1999). The authors argue that the types of practices outlined have achieved a degree of stability and level of agreement but given the dynamic character of positioning and the theoretical assumptions of social constructionism, these are not to be taken as a-priori conversational constructs.

The tri-polar structure of conversation allows for any one of the three points in the triangle to be used as the starting point for a positioning analysis and into which the other elements of the triangle will be progressively collected (Harre and van Langenhove, 1999).

This study is concerned with identifying the discursive doings manifest at the speech act-social actions pole of the triad in these texts. It attempts to explore the extent to which these discursive doings are jointly accomplished and manifest as social actions through the discursive practices of positioning and with what effects for their going on together in conditions of relationship situated within the moral order of the community psychiatric clinic.

3.4.4 A reflexive account of a (my) methodological problem with positioning theory and its link with Fairclough's (1992) text structure analytic elements

Harre and van Langenhove (1999) suggest that a descriptive analysis of the structural features of the text may generate important insights for a position-driven analysis, particularly at the speech acts-action pole of the analytic triad. While this may be the case and makes sense intuitively, the theory does not offer nor suggest specific text analysis tools or how they might be used to enrich the position-driven analysis (van Langenhove and Harre, 1999). Before I introduce the text elements to which I turned to resolve this dilemma, I would like to suggest that it may be possible that I misinterpreted or over-interpreted van Langenhove and Harre's (1999 p. 17) intention in their concluding statements to their illustration of the position/act-action/storyline triad: "**Much more** would be required to complete an analysis. The choices of vocabulary, pronouns and **so on** are crucial elements in the way the effect is achieved".

What could "so on" and "much more" in the context of vocabulary and pronouns mean? If positioning analysis is informed by the theoretical assumptions of social constructionism, and if some kind of text analysis within a positioning analysis is desirable, what other discursive text tools within the field of critical discourse analysis might warrant similar characterisation and be drawn into this study's discursive analysis?

I first turned to the analytic devices of conversational analysis to resolve the much more. These were useful routes of entry into the much more but only in as much as they led me back to Fairclough's (1992) text structure analytic elements of the first dimension of his discourse theory. The so on seemed to have a substance and a place in the analysis. However, its place was not as I had anticipated. I had first thought to integrate the text structure analysis into the positioning analysis of chapter 4 but it would not be forced. On the other hand, I was reluctant to let it go because it yielded a rich body of data about the texts that might not otherwise have been generated.

And then one day someone asked what the study was about and I found myself using the language and substance of Fairclough's (1992) text structure elements and Foucault's ideas about power to describe what turned out to be the starting point storyline for the subsequent positioning analysis. On the basis of this telling, I moved the description of the text structure elements from the analysis to the methodology and used it as a means for gaining entry into the texts and for developing the basic storyline for the subsequent positioning theory analysis. The irony of this new placing for the text structure analysis now lies in my original assertion that such an analysis seems integral to a positioning theory analysis.

However, it has become my understanding that such a descriptive analysis need not necessarily be performed within the context of a positioning analysis but that its language of description might be useful when developing and arguing the

lines of analysis, irrespective of whether it is a position theory, ideological dilemma or Foucauldian angled-analysis.

Fairclough's (1992) text structure analytic elements are very briefly outlined below while an account of how these features were used to inform the methodology of this study and to develop a basic storyline for a positioning theory analysis are discussed in section 3.5.2 and 3.5.3 respectively.

3.4.5 Overview of Fairclough's (1992) three-dimensional theory of discourse

Fairclough's theory of discourse and his analytic approach represent a synthesis of critical linguistic and critical social theory. Fairclough (1992) offers a three-dimensional conception of discourse, each of which overlaps the other and may be used as a point of entry into discourse analysis. Each dimension has a number of analytic elements associated with it and these too, may be relevantly applied across the domains (Fairclough, 1992). The first two dimensions are descriptive (text structure and text production) and the third, interpretive (text and social practice). The first dimension and the one of interest in this chapter, is the text structure and this is presented in the next section.

3.4.5.1 Text structure analytic elements

Text structure refers to the large-scale organisation of the text and includes the interactional control features of turn-taking systems, exchange sequences, topic control, control of agendas and formulations (Fairclough, 1992). Fairclough (1992) argues that these structuring conventions control the smooth working and organisation of conversation and are the mechanisms through which conversation is jointly if somewhat asymmetrically accomplished.

3.4.5.1.1 Exchange structures and turn-taking

Exchange structures are the mechanisms through which turns at talk are recurrently patterned and collaboratively accomplished (Fairclough, 1992; Silverman, 1997, 2001; Tannen, 1989). Mishler (1984) suggests that exchange structures such as the question-answer (Q-A), the information seeking (IS) and information delivery (ID) structures have become entrenched in medical and psychiatric interviewing. Silverman (1997) and others (Borges, 1986; Fischer, 1991; Mishler, 1984; Strong, 1979) argue that the persistence with which these structures appear in the helping discourses suggest they have been normalised as a routine and unproblematic way of doing professional helping.

3.4.5.1.2 Topic control

Most often, topics are raised through the mechanism of the Q-A adjacency pairing where a turn at talk is offered by one speaker (in the first part of the adjacency pair), accepted or rejected by the other (in the second part of the pair) and then developed further by the first speaker in the form of an insertion or elaboration sequence (Silverman, 1997, 2001). Speakers may selectively and persistently attend to particular topics or to aspects of a topic and not others, usually in accordance with a pre-set agenda that may or may not be explicit (Fairclough, 1992; Silverman, 1997). A topic may therefore be raised in conversation but is manifest as a feature of talk only to the extent that it is taken-up or attended to by the participants[12].

3.4.5.1.3 Setting and policing agendas

Agendas are an important mechanism of interactional control in that they

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[12] See section 3.3.4 for an account of take-up in conversation.

shape what can be said, when it should be said, how it can be said and when the saying time is over (Fairclough, 1992). Agendas may be explicitly formulated at the beginning of the interaction (or at some later point) or implicitly inferred from the function of the context within which they occur (Silverman 1997).

An agenda is designed to elicit key information and particular descriptions, the forms of which may be quite tightly controlled or as Fairclough (1992) suggests, policed through a variety of discursive mechanisms. Policing mechanisms include question-answer exchanges, topic control, interruption and closed-ended questions. Closed-ended questions, that is, those which offer a yes/no or very limited response options, are the most commonly used policing mechanisms in institutionally situated episodes of interaction, including counselling (Mishler, 1997; Silverman, 1997). Although Perakyla and Vehvilainen (2003) regard the "wh- questions" as open-ended and therefore less controlling, Fairclough (1992) suggests they are designed to elicit specific kinds of information and to this extent, also work to police the agenda.

3.4.5.1.4 Formulations

Formulations are statements about the conversation, in other words, they are second order accountive comments which either speaker may make in an attempt to explain, describe, characterise, translate, explicate, summarise or comment on some aspect of the conversation and its correspondence with or departure from particular institutional or other norms and rules (Fairclough, 1992; Mishler, 1997; Silverman, 1997). Formulations are important to the process of meaning making in conversation (Gergen, 1999). The most commonly occurring forms of formulation are forcing acknowledgement or explicitness in the face of ambivalence, hedging or silence "so what you are saying is..." or by making moral judgements or pronunciations about aspects of the client's contributions, "everyone has their ups and downs in life, even me too" in response to the client's description of a series of tragic events (Fairclough, 1992; Gergen, 1999; Mishler, 1997). Formulations may have a normalising effect

particularly if they call speakers to account for their actions and behaviours from within a particular moral order of speaking (Gergen, 1999; Harre and van Langenhove, 1999).

For example, the nurse's comment "otherwise, you are happy with your medication" is a formulation or re-wording of the client's description of his wellness and his desire to be taken off medication. In this example, the formulation draws its authority from the moral order of the psychiatric medication clinic and in so doing, shapes what is possible for both speakers to say in the particular context. In this respect, formulations work to maintain or to return the interaction to the norm that is, to the norms underpinning the conversational agenda (Fairclough, 1992).

While formulations share a similarity with second order positioning-talk (in their explanatory and directive effects) they do not speak as clearly to the coercive mechanisms and effects of talk as positioning theory. The subsequent analysis therefore sees formulations as working across first and second order positioning practices and distinguishes between specific positioning practices upon the degree of struggle for interpersonal meaning in the unfolding episodes of interaction.

3.4.6 Building a reflexive bridge between Fairclough's text structure elements and the process of this analysis

The decision to use Fairclough's (1992) text structure elements rather than those of conversational analysis, or any other approach, was taken for four related reasons. Firstly, the language of conversational analysis itself is quite technical (Billig, 1999). Although Silverman (2001) suggests conversational analysis is not difficult to do and his three-point plan seems simple enough, the descriptive terms and devices it uses are at the very least, a technical mouthful.

Secondly, Fairclough (1992) quite obviously links text features to broader

issues of identity, social practice and power and this kind of linkage beyond the text fits with the theoretical assumptions and atmosphere of this study and the unfolding analysis. These kinds of linkages are not traditionally the focus of conversational analysis although some experienced social science researchers are able to work easily across these intellectual domains (Silverman, 2001; Wetherell, 1998). Although the study does not set out to explicate specific linkages between textual happenings and broader patterns of social practice, it does make forays into the discourses of the broader psychiatric social world.

In the third place, the kinds of features Fairclough (1992) describes in the text structure aspect of the text dimension are similar to some of those of the corpus `therapeutic psychiatric nursing communication skills' discussed in chapter two and with which I am familiar. This similarity between the two discourses helped me to find a point of entry into these texts that appeared at first, as an impenetrable mass of text data.

3.4.7 Conclusion

This section has set out in detail, the social constructionist assumptions of the study. The analytic devices of the study, namely positioning theory, were situated and described within the broader ambit of discourse analysis. This was followed by a reflexive description of the methodological dilemma I encountered while developing the analytic framework for the study and of how an ungainly return to Fairclough's (1992) discourse theory for a set of text structure analytic elements helped to ease the dilemma.

The study now turns to a description of the methodology and shows how the process of analysis unfolded and how the various analytic devices helped to both find a point of entry into the text and to develop a discursive insight for a position theory analysis.

3.5 The 4 non-steps[13] of the unfolding discourse analytic methodology for this study: Level one analysis

This study seeks to analyse the discursive activities present in student-psychiatric nurse-client talk and to provide a social constructionist account for how these activities can be understood and with what general implications for modern psychiatric nursing practice.

The methodology draws upon a synthesis of the stages of discourse analysis outlined by Parker (1992), Potter and Wetherell (1987), Silverman (2001) and Willig (2001). All of these authors speak of the non-steps in discourse analysis as involving at least four steps, that is, the phases of generating texts, gaining entry into the texts, developing a preliminary account of the effects of the texts within the context of the research focus and finally, the analysis which reflects both the research question and the emphasis of the analysis. The following three steps are the substance of the methodology while the final is the core of analysis.

3.5.1 Generating texts

Texts are the analytic objects of a social constructionist analysis. Parker (1992) defines texts as "... delimited tissues of meaning reproduced in any form that can be given an interpretive gloss." (p.6). Fairclough (1999) argues that texts constitute a major source of evidence for grounding claims about social structures, relations and processes and for evidence of these on-going social processes, such as the redefinition of social relationships between professionals and the public. In the case of this study, the texts refer to episodes of student psychiatric nurse-client psychiatric clinic-based interaction, transformed into written form and given an interpretive

[13] Most writings on discourse analysis make it clear that DA is not a stepped process and then go on to offer guiding parameters.

gloss through the process of transcription notation and discursive analysis.

3.5.1.1 Selecting (purposive sampling) instances of talk for text

Twenty pre-existing instances of audio-recorded talk between student psychiatric nurses and psychiatric clients at a psychiatric community clinic were purposively selected for their resonance with the focus of the study (Silverman, 2001; Willig, 2001). These recordings are not part of a bigger data set and are the recordings of the twenty nursing students registered for mental health nursing over a period of two years and who were willing to participate in this study.

These twenty instances of talk were recorded by the researcher-as-educator over a two-year period, some of which were used in class for educational purposes. Ten recordings were made in the first half of this period and ten in the second. Verbal consent to use this pre-existing data for this study was obtained from the twenty undergraduate nursing students. The issues of consent are further outlined in section 3.7.1, page 119.

Seven recordings were finally selected for transcription and transformed into text, based upon the following criteria. Firstly, all twenty recordings were rated for audibility. A recording was considered for transcription if in the researchers opinion, at least eighty percent of the dialogue was audible to the researcher and therefore able to be transcribed. All the data were collected in the same way and with the same instrument. However, the settings within which data were collected differed from private to public spaces and from quiet to very noisy places, thus interfering with the sound quality. Therefore, although audibility is not necessarily a standard criterion for purposive sampling, it is regarded as appropriate for this study. Ten recordings met this criterion.

Secondly, the ten recordings were combed for their interactional completeness. The study is developed around an analysis of the doings of student psychiatric nurse-talk in episodes of interaction that are traditionally understood within the context of a specific interpersonal objective, namely, the nurse-patient relationship (Armstrong and Kelly, 1995; Forchuk and Reynolds, 2001; Hagerty and Patusky, 2003; Muller and Poggenpoel, 1996). Although this study is not embedded within the construct of the nurse-patient relationship as it is defined in modern psychiatric nursing theory, the subsequent analysis and its theoretical grounding may need to draw upon or at least refer to, the stages[14] embedded within this construct (Gergen, 1999). Therefore, the relational activity of gaining entry, maintaining and terminating the interaction, is considered an important selection criterion. Three recordings were excluded on the basis of this criterion. Two of these recordings began in what seemed like a third of the way into the interview while the third ended in the middle of a discussion about family matters. The final seven instances of talk were transcribed into text.

3.5.1.2 Introducing the text-speakers to the study

Basic demographic data about the speakers and the texts is given in Table 1 (page 100). The purpose of this profile is to introduce the speakers in the texts to the study, rather than to add the potential discourses of gender, age and ethnicity to the texts (Silverman, 2001). This is obviously not to suggest that these features are unimportant to qualitative research in general. Willig (2001) argues that the routine provision of demographic data about speakers is not always appropriate for studies concerned with how particular social realities – of which gender, race and culture may be examples - are constructed in language. She highlights the socially generated meanings of these categories and suggests that if they are used in a study without

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[14] See section 2.4 Chapter 2.

sound theoretical purpose, they are a further way of constructing and re-constructing discursive identities (Willig, 2001). The focus of this study is not on manifesting the intentions of individual speakers but with the discursive doings generated in instances of dialogue. It is significant that the speakers in these texts are nurse and client and this is already manifestly obvious.

Table 1: Data about the speakers and the episodes of interaction

Transcript Number	Duration of interview	Client speakers (Ages range between 40 and 60 years)	Student nurse speakers (Ages range between 25 and 28 years)
1	3 minutes	Male	Female
2	5 minutes	Female	
3	4 minutes	Male	
4	50 seconds	Female	
5	11 minutes	Male	
6	15 minutes	Male	
7	10 minutes	Female	

3.5.1.3 Transforming speaker-talk into text

The aim of transcription is to provide an adequate description of the talk between student-psychiatric nurses and clients in these episodes of interaction (Silverman, 2001). However, speech and text are not fully equivalent (Mishler, 1984). Transcription imposes an interpretation on speech because the particular rules and conventions broadly define what is textually relevant and significant (Fairclough, 1992; Mishler, 1984). Mishler (1984) suggests that transcription is the first level of textual analysis because it provides some kind of structure and therefore coherence on what at first seems like an impenetrable mass of sensory data.

There is a diversity of transcription approaches, all of which offer subtly different routes of entry into the texts and which to varying degrees, illuminate the researcher's field of interest in the texts (Potter and Wetherell, 1987). In this respect,

transcripts are not a reflection of "what is there" but of what is made intelligible through the particular way of seeing (or transcribing). This is not to suggest that transcription is necessarily an inaccurate reflection of talk but rather, a reminder that the process of rendering speech into text is dialogically linked to the theoretical assumptions and research interests underlying transcription (Fairclough, 1992; Mishler, 1984; Ochs, 1999; Potter and Wetherell, 1987).

3.5.1.3.1 Silverman's (1997 and 2001) notations

I have settled on two forms of notation for these texts. The first form is drawn from the work of Silverman (1997) and includes the common symbols used in traditional conversational analysis where the focus is on reflecting speech and its nuances in text in the most life-like way as possible. These conventions detail a range of features of talk and I found these conventions particularly useful in forestalling or at least reducing my on-going impulse to "tidy up the talk" in the transcription process. The notations are given below and then illustrated in Illustration 3.

Illustration 1 Silverman's (1997 and 2001) Notations

[	*Bracket indicates the point at which a current speaker's talk is overlapped by another's talk.*
=	*Equal signs, one at the end of a line and one at the beginning, indicate no gap between the two lines.*
(.2)	*Numbers in parentheses indicate elapsed time in silence in tenths of a second.*
(.)	*A dot in parentheses indicates a tiny gap, probably no more than one-tenth of a second.*
Help	*Underscoring indicates some form of stress via pitch/loudness.*
O:kay?	*Colons indicate prolongation of the immediately prior sound. The length of the row of colons indicates the length of the prolongation.*
HELP	*Capitals (except at the beginning of the line) indicate especially loud sounds relative to the surrounding talk.*
hhhh	*A row of hhh indicates a breath sound. The length of the row indicates the length of the breath.*
( )	*Empty parentheses indicate transcriber's inability to hear.*
(help)	*A word in parenthesis suggests possible hearings.*
((Help))	*Contains author's descriptions rather than transcriptions.*

3.5.1.3.2 Mishler's (1984) notations

A further level of transcription notation was applied to these texts in respect of the interactional control features outlined by Fairclough (1992). I used and adapted Mishler's (1984) transcription notations to organise the transcripts into question-answer conversational cycles. These are described here and presented in Illustration 2 below.

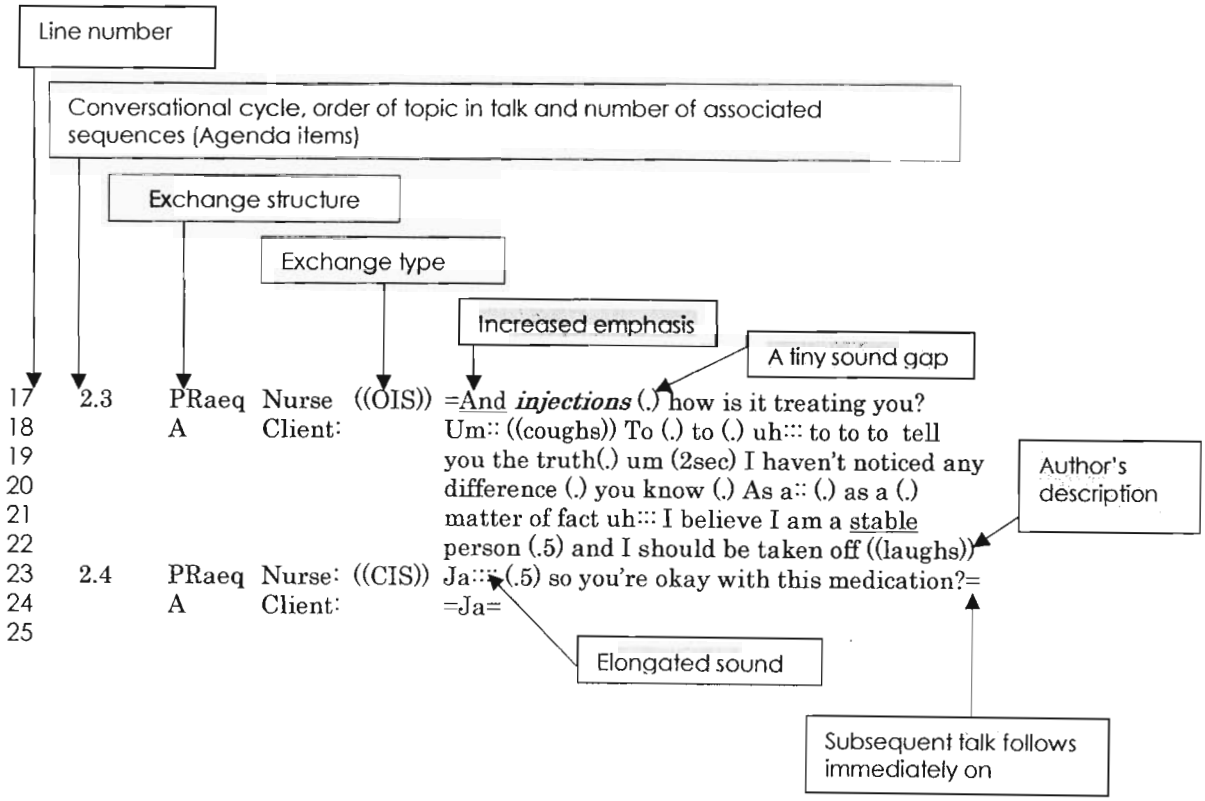
Each cycle roughly corresponds with a particular topic and may have one Q-A exchange sequence or a series of Q-A elaboration sequences associated with it. The topic of the cycle is **bolded** in the text. The conversational cycles and their insertion sequences are numbered to the right of the line numbering. The first number references the order of the topic in-talk, and the number next to it signifies the number of question-answer sequences associated with the cycle-topic. The type and focus of the nurse's questions are summarized in double parenthesis to the left of the nurse's utterance.

Illustration 2 Mishler's (1984) Notations

Praq	*Means post response acknowledgement followed immediately by a question about another topic.*
Praeq	*Means post response acknowledgement followed immediately by an elaboration question.*
Praid	*Means post response acknowledgement followed immediately by an information delivery sequence.*
A	*Means client's answer.*
(( ))	*The symbols in double parentheses to the right of the nurse-speaker classify the broad function or type of exchange structure:*
	((O)) Is an open type of question.
	((C)) Is a closed type of question.
	((F)) Is a feeling focussed question.
	(IS)) Is an information-seeking question.
	((So)) Is a solution-focussed question.
	((ID)) Is an information-delivery sequence.
	((Form)) Is a content formulation

These additional notations are illustrated in Illustration 3 through an excerpt taken from transcript 6, below. In this excerpt, line 17, the topic of medication is being discussed. The numbering (2.3) shows that medication is the second conversational topic on the agenda and that two elaboration sequences about medication have preceded this third elaboration sequence (Praeq). ((OIS) shows that the nurse's utterance is an open, information seeking type of exchange.

Illustration 3 Mishler's (1984) and Silverman's (1997 and 2001)adapted notations



The duration of the episodes of interaction, vary from 50 seconds to 15 minutes and the time taken to develop a first text draft of each interview varied accordingly. On average, it took about seven hours to develop the basic first drafts and approximately 160 hours thereafter to apply (and to re-apply and to settle) the organisational feature notations in the texts.

3.5.2 Routes of entry into the texts reading for awareness

Willig (2001) speaks of reading the texts for their effects as a way of developing an awareness of what the texts are doing, that is, their social actions. Parker (1992) describes reading for awareness as a process of exploring the possible connotations, allusions and meanings, which the texts call forth. He suggests the process might be initiated by asking, "What is this text shouting at me and what kind of role do I have to adopt to hear this message?" The texts have shouted in many different voices, at odd times and from different vantage points, particularly during the transcription process and in organising the transcripts into conversation cycles. Clearly, this process is an interpretive one and carries with it, fragments of the researcher's own experience as a psychiatric nurse and nurse educator.

The purpose of reading, re-reading and notating is to develop a clear account of what the texts might be doing - their social action orientation - while the purpose of analysis is to identify precisely how the texts accomplish this (Willig, 2001). The following two sections show the route I took to enter the texts, the lenses I used to make sense of what I was reading and 'hearing' and finally, the storyline I settled with as the starting point for the subsequent positioning analysis.

3.5.2.1 The lenses of Fairclough and Foucault as a route of entry into the texts

In this section, I would like to show how I used some of Fairclough's (1992) analytic text structure features and some of Foucault's ideas (Smart, 1985) about power (or at least, the language of his analytics of power) to develop my early impressions of an overall atmosphere of psychiatric watching and its potential effect on talk in these episodes of interaction.

The weight of the presence of the psychiatric looking over atmosphere at work

in these texts might be the consequence of a range of text structure features - question-answer exchange structures, turn taking, topic control, agenda setting and formulation - which when taken together, have the effect of working to a particular agenda with surveilling effects (Fairclough, 1992; Gilbert, 2002; Holmes, 2001; Mishler, 1984). The term surveillance[15] is used here in the spirit of Foucault, as a particular kind of 'looking over' wherein one of its effects is to illuminate the specific attributes or processes in the individual with which the particular disciplinary gaze - in this case, the gaze of student psychiatric nursing- is concerned (Mills, 1997; Smart, 1985). In this section, I turn to the tool of numbers to develop a weighty case for the presence of a psychiatric agenda with surveilling effects (Berman, Ford-Gilboe and Campbell, 1998).

3.5.2.1.1 An agenda for diagnostic psychiatry

An agenda for surveillance, that is, of looking over is explicitly established in the nurse-speakers opening sequences of each text: "How have you been over the past month?" (Transcripts 1, 2, 3, 5, 6, 7) and: "Any issues of concern?" (Transcript 4 Appendix D). These opening utterances suggest the client's well being over time is the focal point of the interaction while the interaction's situatedness within the moral order of the psychiatric clinic, gives the agenda a psychiatric gaze. The agenda for this gaze and its surveilling effect is progressively manifest as the interactions unfold and specific functional aspects of the clients are first highlighted and then if necessary, explored.

In the first place, almost all the exchanges in the texts are organised around cycles of questions from the nurse and responses from the client (Fairclough, 1992; Mishler, 1984). Table 2 below shows that 86% (147) of the total number of exchange sequences (196) are of the question-answer type, almost all of which are initiated by

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[15] See section 3.3.7.7.1 for a fuller account of surveillance.

the nurse. Clients do take the conversational floor (2% of the topics are client-initiated) but almost always when a turn is offered, usually in the form of a question (Silverman, 1997).

A second type of exchange sequence, namely information delivery, was found to be at work within the texts although it is not as prominent or as persistent as the Q-A structure. In this respect, 26 information delivery exchanges were identified, all of which are organised around medication, collecting medication, attending the next appointment and changing sleeping patterns.

Table 2: Summary of exchange sequences

Transcript number	Total number of conversational/ topical cycles	Total number of exchange sequences	Types of Exchanges						Types of Questions		Speaker-initiated	
			Question-Answer Exchanges (Q-A)									
			Information seeking (IS)	Feeling-focussed (F)	Solution-oriented (SO)	Formulations (Form)	Total Q-A	Information Delivery (ID)	Open (O)	Closed (C)	Nurse	Client
1	5	11	7	3	0	0	10	1	3	7	5	
2	5	26	18	1	2	0	21	5	8	13	5	0
3	7	17	14	0	0	0	14	3	12	2	7	0
4	6	7	5	0	0	0	5	2	2	3	6	0
5	6	38	25	2	0	1	28	10	9	19	6	0
6	12	58	51	0	1	5	57	1	19	38	13	0
7	11	39	27	2	0	6	35	4	8	27	10	1
Al	52	196*	147	08	3	12	170**	26	61	109	52	1

In the second place, an obvious effect of the Q-A exchange sequence is the extent to which the nurse, through her control of the basic organisation of the interaction, controls the topic of conversation. Table 3[16] summarises the topics raised in each text, their order in talk and the number of elaboration sequences associated with each topic. Roughly, fifteen topics were jointly attended to in the texts, all of which resonate with those of diagnostic psychiatry (Horwitz, 2002). The most frequently talked about topics in these texts in descending order of frequency are:

- Medication efficacy and the details of the next appointment (present in 7 out of the 7 texts);
- Wellbeing over the past while and family wellbeing (present in 6 out of the 7 texts);
- Sleeping and eating patterns and an invitation to talk about other worries (present in 5 out of the 7 texts); Place/people of residence (present in 3 out of 7 texts);
- Presence of mood symptoms and psychotic symptoms (present in 2 out of the 7 texts);
- Finances, recreation, religion, social relationships, work patterns and an invitation to talk about whether talking helps (raised once out of the 7 texts).

In the third place, not only are the majority of the nurse-speakers questions concerned with topics psychiatric, but also with collecting specific, differentiated pieces of information about the extent to which the clients functioning with respect to each topic is "okay" or "fine" or "much better". Table 4 shows that of the total number of Q-A exchanges (170), the majority of them (147) are directed towards gathering information about the client's functioning. Further, most of the questions

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[16] Table 3 can be found at the end of this Chapter because it is set in landscape and its placement here interferes with the readability of the chapter.

within each topic exchange cycle are closed-ended (64% of the total number of Q-A exchanges), which suggest that a specific type of information is being sought.

Some of these questions directly restrict the content and form of the clients' answers to a yes or no, for example: *"are you still taking your medication?"* (Transcript 2, Appendix B line 5-6); *"sleeping well, eating well?"* (Transcript 4, Appendix D line 7); *"do you hear voices then?"* (Transcript Five, Appendix E line 89). Others such as the "wh-questions" are more open but are designed to elicit specific details from the client about the extent of the problem, its manifestations, duration, frequency, and intensity. For example: *"When did sleeping afternoons start?"* (Transcript 3, Appendix C line 14); *"Then can you tell me more about it ((bad sleeping))?"* (Transcript 2, Appendix B line 72); *"Since you are not working, what is it that you do during the day?"* (Transcript 6 Appendix F 129-131); *"When was the last time you heard strange voices or you know saw people who are not there?"* (Transcript 6 Appendix F lines 149-153). Although the criteria for what constitutes "much better" are not stated, the point at which the nurse-speakers close one cycle and move on to the next suggest that some kind of normative evaluation has been made (Fairclough, 1992; Mishler, 1984; Tannen, 1989).

Table 4: Summary of types of exchange sequences

196* exchange sequences (Column 3 Table 2 above):
▪ 170 (87%) are question-answer exchange types
▪ 26 (13%) are information-delivery Q-A exchanges
170 Q-A exchange types (Column 8 Table 2 above):**
▪ 147 (86%) are information-seeking exchanges
▪ 8 (5%) are feeling-focussed exchanges
▪ 3 (2%) are solution-oriented exchanges
▪ 12 (7%) are content formulations
▪ 61 (36%) are open-ended types of questions
▪ 109 (64%) are closed-ended types of questions

In the fourth place, the selective ways in which the nurse-speakers generally take up the responses of the clients further reinforces the idea that they are working to a pre-set agenda (Fairclough, 1992). In the main, the nurse-speakers generally focus on the psychiatric, medical or concrete events "what did he say then" of the clients accounts. This is exemplified in the example below (Excerpt 4), taken from Transcript 2, Appendix B. The talk preceding this excerpt has been focused on the client's problem of not sleeping well (line 71). The speakers establish the problem has been going on for a few months (line 76), that the client goes to bed early (lines 77-81) and that sometimes she does not sleep at all because the tablets don't help (line 86-88). The nurse suggests the client go to bed later but the client says she "*can't sleep late*" (lines 93-94).

Excerpt 4: Agenda for diagnostic psychiatry (Transcript 2 Appendix B lines 95-114)

95	4.7	PReq	Nurse: ((OSo))	Okay (soft laugh)) hhh so:: (.5) what do you
96				suggest you will do then?
97		A	Client:	(2sec) ((Laughing softly)) You should tell me.
98	4.8	PRaID	Nurse: ((ID))	((Laughs softly)) Well I suggest that you (.) go
99				to sleep later then. ja::. maybe (Client: Mmm:)
100				it might help you(.) ja.
101		A	Client:	Sometimes when I go to sleep to:: (.) I can't
102				sleep because of these pains that I've been
103				getting you (Nurse: Mmm) know.
104	4.9	PRID	Nurse: ((ID))	(2sec) Then I suggest that maybe you (.)
105				should go to see a doctor then=
106		A	Client:	=I'm under a lot of stress too (.) you see.
107	4.10	PReq	Nurse: ((CIS))	(2sec) Then what (.) Okay (.) What (.) about
108				your boyfriend?
109		A	Client:	He gives me too much problems. too much. He
110				((boyfriend)) worries me a lot.
111	4.11	PraID	Nurse: ((ID))	(5sec) Ja. I see (4sec) but I suggest that you go
112				(.) to (.)bed later than (.5) later than six.
113				Maybe at nine (.) or eight (.5) then maybe (.) it
114				might help you=

The nurse re-states her suggestion of sleeping later and the client again refuses

the suggestion and shifts the explanation for her not sleeping to the pains she has been getting (lines 101-103). The nurse bypasses this life world explanation and focuses instead on the medical aspect of "seeing the doctor". The client bypasses the nurse's response and emphasises the stress she is currently experiencing. The nurse quite reluctantly attends to the source of her stress in the form of a question filled with pauses and speech hesitancies (lines 107-108). The client again emphasises the boyfriend as the source of "too much" and "a lot" of stress without elaborating further. The nurse sidesteps the client's experience of her problem and takes up the mantle of "going to bed earlier than six" as the source of her sleeping badly. The texts are peppered with examples such as this. On the other hand, there are fleeting instances of facilitated expressions of client agency and these are discussed in the section below.

Finally, there is a very clear sense within these texts of both speakers being called to formulate their utterances from within a psychiatric rather than any other agenda or moral order of speaking (Fairclough, 1992; Mishler, 1984). The frequency with which the nurse-initiated, diagnostic psychiatry information-seeking exchanges occur in the texts suggests that it is primarily the client who is called to formulate his/her utterances from a psychiatric perspective. However, it is this same frequency and weight, together with the closed-ended nature of the nurses' questions and their selective uptake that gives the impression of the nurses' as accounting for their actions to a higher authority, that is, to the principles and practices of the psychiatric clinic.

3.5.2.1.2 Last minute additions to the agenda: Person-focus

In my reading of the texts, I could find only fleeting instances of a client-centred or life world focus in the nurse-speakers utterances. Examples include: "*So you're saying it's not easy staying at home not working?*" (Transcript 1, Appendix A, lines 30-31); "*Do you get upset about that=how does it make you feel?*" (Transcript Five,

Appendix E lines 113-114); *"With you?=and then (.) How does that make you feel?"* (Transcript 2, Appendix B lines 48-49); *"I see its making you depressed speaking about him. It's okay to cry* (.)…?"(Transcript 7 Appendix G lines 198-201).

This is not to suggest that these kinds of life-world doings are absent in the client's utterances. On the contrary, the texts are filled with client-attempts to speak from the position of their life world. However, the extent to which these expressions are taken up by the nurse as expressions of life-world and manifest as distinctive social actions in the unfolding conversation, varies. Since this is largely the substance of the forth-coming analysis, a single example will be given to illustrate this point.

The nurse-speaker in Transcript 3, (Appendix C lines 17-40) asks the client whom he lives with. The client responds from the position of husband and father and offers a personal account of the activities of his family members. The nurse responds to this expression of life-world with a new question about how the family copes with "life expenses". An impoverished financial status is one of the potential stressors associated with relapse and therefore, a critical normative criterion for psychiatric assessment (Horwitz 2002). While this may be the case, family relationships are equally important to this moral order, and for the same reason. It is possible that the client's reporting of his experience of his family provided the nurse with sufficient data to make the judgement that everything was "okay" in family relationships. In this instance, the expression of life-world is taken as indicator of psychiatric wellness and the accomplishment of the item "family relationship" on the psychiatric agenda.

The kind of psychiatric nursing watch being kept in these texts resonates with the discursive activities of assessment and judgement of diagnostic-psychiatry and of the psychiatric nursing process (Horwitz, 2002). From a positioning theory perspective, it is possible that one of the effects of the psychiatric agenda is the extent to which it requires both speakers (and not just the nurse) to account to it and to draw from it in order for their social acts to be mutually intelligible as social actions

within the moral order of the clinic (Gilbert, 2001; Mishler, 1984; Silverman, 2001).

3.5.2.1.3 Concluding comments

This section has attempted to make a case for the presence of a psychiatric agenda with surveilling effects in these texts. This case is made based upon the justification for using analysis to illuminate the methodology given in section 3.2 and specifically, to account for how the third step of the discourse methodology for this study was accomplished, that is, of developing a preliminary account of the effects of the texts (see the introductory paragraphs of section 3.5).

3.5.3 The agenda for a positioning theory analysis

Student psychiatric nurse talk within these episodes of interaction potentially works to normalise expressions of client-agency and the client-centred potential of nursing practices within the direction of the broad diagnostic-psychiatric agenda or storyline. I have taken this storyline as the focal point for the positioning theory analysis in chapter four, which is the fourth and final "non-step" of the discourse analytic method for this study.

3.6 Methodological goodness and completeness

Rigour is the means by which the legitimacy and integrity of the research process is adequately established (Buus, 2005; Morse, 2006 [1]; Silverman, 2001; Tobin and Begley, 2004; Willig, 2001). It has been variously argued that the trinity of the concepts - validity, reliability and generalisation – used to establish rigour in rationalist research may not be relevant for evaluating the integrity of constructive or progressive qualitative research because of their different standpoints on what constitutes knowledge, and how it is generated and understood (Chiovitti and Piran,

2003; Holliday, 2002; Silverman, 2001; Slevin and Sines, 1999; Tobin and Begley, 2004; Willig, 2001).

Most of the current debate about rigour in qualitative research is built around the ideas of trustworthiness and its related criteria developed in the 1980's by Lincoln and Guba (Chiovitti and Piran, 2003; Slevin and Sines, 1999; Tobin and Begley, 2004). These ideas have provided the basis for contemporary theorising about and critique of how the concepts of validity, reliability and generalizability may be articulated outside of the discourse limits of the rationalist paradigm (Chiovitti and Piran, 2003).

Tobin and Begley (2004) argue that currently applied criteria for rigour in interpretive or naturalistic qualitative research – trustworthiness, confirmability and transferability - parallel those of the "trinity of truth" of the rationalist paradigm. It is therefore possible that their application may be inconsistent with the epistemology and aims of some qualitative studies, particularly those rooted in the philosophical idea of constructed, multiple realities or "truths" (Chiovitti and Piran, 2003; Slevin and Sines, 1999; Tobin and Begley, 2004). The theoretical assumptions underlying this study suggest that social phenomena, including research paradigms, are constructed in language in dialogue (Gergen, 1999). If this is the case, then the language conventions and rules for assessing the quality and legitimacy of research undertaken from this perspective must be consistent with its philosophical origins (Chiovitti and Piran, 2003; Gergen, 1999; Tobin and Begley, 2004).

For example, Smith and Deemer (in Tobin and Begley, 2004) and Holliday (2002) argue that some of the credibility-check strategies used in the naturalistic qualitative paradigm such as member checking and peer-debriefing, may be philosophically inconsistent with a paradigm of multiple realities. Parker (1992) and Holliday (2002) propose that some forms of progressive inquiry are more concerned with elaborating meanings that go beyond individual intentions and therefore, beyond subjective experiences of reality.

Tobin and Begley (2004) suggest that it is possible to establish the rigour of a study situated in a paradigm of multiple truths if the idea of rigour is understood to include the ideas about goodness and a triangulation state of mind, with respect to the framing of the study, data generation, epistemology, analytic devices and interpretive outcomes. Tobin and Begley, (following Mishler in Tobin and Begley, 2004) and Holliday (2002) propose that these ideas about rigour are integral components of the research process made visible in the workings of the study.

The idea of goodness includes notions of declared subjectivity, clarity, creativity and consistency across the study (Chiovitti and Piran, 2003; Holliday, 2002; Tobin and Begley, 2004). Whereas triangulation is traditionally understood as the use of mixed methods to confirm findings, Tobin and Begley (2004) emphasise that triangulation as a state of mind may be used to enlarge, to enrich and to deepen the landscape of the inquiry and the analysis, thereby offering a thick and more complete picture. Thus, triangulation - in the form of two or more theories, methods, approaches, instruments or investigators providing data on the topic – is a means of establishing depth and transferability, rather than confirmation in qualitative inquiry (Holliday, 2002; Tobin and Begley, 2004).

Buus (2005) argues that many nursing studies published between 1997 and 2003 and using discourse analysis show methodological weaknesses in their workings which affect the integrity and consistency and ultimately, the rigour of the studies. He explored 74 published nursing studies in an attempt to identify the versions of discourse analysis nurse scholars' used and the rigour with which the methods were applied. Rigour in this exploration was defined with respect to the degree of consistency between the framing of the study within the field of discourse analysis, the units of analysis and the interpretation of the data. Of the 74 studies analysed, 37% demonstrated very little consistency, 41% some consistency and 22%, high consistency (Buus, 2005). Although I do not necessarily agree with parts of his

analysis, the questions he used to generate the data for his analysis may be usefully applied in exploring the internal consistency and integrity of this study. I have posed and answered these questions in section 3.6.1.

Transferability is a highly contentious issue in studies located in a paradigm of multiple truths (Holliday, 2002; Willig, 2001). Silverman (2001) suggests that where settings are contextually similar, findings may have application, but with caution. Slevin and Sines (1999) argue that transferability may be enhanced through multi-site investigation, by offering rich and dense data, using a systematic approach and by focusing the study on the typical. Focusing on the typical references the extent to which the sample, from which the data is drawn, is thought to be typical of the research site and subjects (Slevin and Sines, 1999). Typicality assumes that a particular kind of truth about the reality under study is being sought and it is therefore not necessarily a useful principle in studies grounded in a constructive paradigm.

The meanings of the terms rich and dense data and systematic approach respectively parallel Tobin and Begley's (2004) triangulation as a state of mind, and Buus (2005) ideas of consistency. Although transferability is neither a goal nor measure of quality in constructive research, its findings may have application in other contexts (Holliday, 2002; Silverman, 2001; Willig, 2001). Holliday (2002) and Durrheim and Wassenaar (1999) suggest that if a rich and detailed description of the contexts framing the emerging structures of meaning is given, then these emerging structures may be transferred to new contexts as a way of exploring how meanings are generated in the new context.

3.6.1 How rigorous is this study?

I have attempted a brief, reflexive analysis of the completeness and consistency of this study, using Tobin and Begley's (2004) idea of triangulation as

completeness and the questions posed by Buus (2005) to establish the study's consistency and integrity.

3.6.1.1 Triangulation state of mind as offering depth

If Tobin and Begley's (2004) idea of a triangulation state of mind as providing depth is an indication of rigour, then the use of three philosophically consistent approaches in this discourse analytic study, namely Fairclough's text analytic dimensions (1992), Harre and van Langenhove's (1999) positioning theory analysis and some of Foucault's ideas about social power (Smart, 1985) may offer the study a depth which each on their own might not have been able to do.

3.6.1.2 Consistency as offering goodness

If the questions posed by Buus (2005) in his analysis of the extent to which consistency and integrity is a feature of published nursing discourse analysis studies, are applied to this study, then this study demonstrates if not high then at least, more than some consistency.

Question One: ***How is a (the) study framed as an analysis of discourse?***

The study's social constructionist framing is consistently highlighted and attended to across chapters 3, 4, and 5. Within this framing, it focuses specifically upon conversation as both the substance of social reality and the resource for its study (Harre and van Langenhove, 1999; Parker, 1992).

Question Two: ***Which analytical units are used in the analysis of discourse?***

The analytical units used here are episodes of student-psychiatric nurse talk occurring in the community-based psychiatric clinic context, transformed into text and then subjected to a positioning theory analysis of the discourses illuminated in

the texts. The action-effects of the positions/social force/storyline positioning triangle are the point of entry into the analysis. These analytic units are understood to be social constructions of how talk might be analysed and are not regarded as a-priori features of conversation.

Question Three: ***How are data contextualised for interpretation?***

Texts were subjected to a first level of analysis through the use of three transcription approaches. These approaches reflect a critical (Fairclough, 1992) descriptive (Silverman 1997) and organisational (Mishler, 1984) approach to transcription. The analytic devices of positioning theory were then used to identify textual units for analysis, interpretation and explanation. Elements of classical psychiatric nursing theory, emerging critical psychiatric nursing threads and the moral context within which the talk occurs are woven into the analytic interpretations and subsequent recommendations for practice.

Question Four ***What on the basis of the first three questions, is the consistency between these elements?***

If rigour is established in the workings of a study through on-going attention to theoretical, methodological, analytical and interpretive decision-making, then rigour is a feature of this study.

From this perspective, integrity and consistency should be manifest in the theoretical context; the methodology; the explicit descriptions about data collection and management; the extent to which the researchers' subjective and theoretical reflections demonstrate a logical understanding of the degree of fit between theoretical context, methodology and data collection; in the process of presenting new insights through the data, the methodology and within the scope of limits of the study; and finally, through the implications for professional practice (Buus, 2005; Tobin and Begley, 2004).

3.6.1.3 Triangulation state of mind and consistency as offering some transferability between sites

The depth (completeness) and consistency of the study and the potential transferability of the findings may be enhanced by the rich descriptions of the context within which the discursive doings of student psychiatric nurse-client talk were generated. The contexts framing this study have been extensively described in chapter two. Holliday (2002) suggests that constructive research findings may be used as a framework for exploring how meanings – in this case, the discursive doings - are developed and generated in other contexts with a similar atmosphere.

3.7 Ethical considerations

Tobin and Begley (2004) suggest that standards of rigour are simultaneously ethical standards. These are outlined below.

3.7.1 Generating ethical texts

These texts were developed from pre-existing audio-taped data sources of student psychiatric nurse-psychiatric client interviews, already in the custody of the researcher in her capacity as facilitator for the psychiatric nursing/mental health component of the Bachelor of Nursing programme.

These recordings were made over a period of two years by the students and me as a mechanism for learning about the ins and outs of therapeutic conversation. The students were required to use these recordings to retrospectively reflect upon and to analyse their interactions with clients in the clinic. Written consent to tape-record the interview and to use and to retain the contents for on-going educational, supervision and professional development purposes is obtained from each client. It

should be noted that the clients at this clinic are very familiar with the purpose and process of this procedure because it has been common practice over the past ten to fifteen years. Nevertheless, the purpose of the recording and who will have access to it – student, other students in training, therapeutic team, facilitator - is explained to each client before consent is agreed.

Only those clients who are considered competent to give consent, that is, who are not actively psychotic at the time, are approached to participate in this learning exercise. Clients are given the opportunity to refuse to participate in the exercise and the forms are usually co-signed by a registered nurse. These consent forms are kept in the clients' clinic files. Total anonymity is given to each client. No identifying data, other than age, gender and ethnicity is required for this educational and professional development activity.

As already noted in chapter one the original idea for this study emerged out of discussions with students about what it is that they do in their clinic interviews with clients, and how their doings accord with their own and with contemporary understandings of psychiatric nursing. These discussions developed with each subsequent hearing of a recording, alongside the process of conceptualising what this study might focus on.

Once the idea for the study had crystallised, I approached the students for verbal consent to use these recordings for this study. All of them agreed and gave verbal consent. Again, they were assured of total anonymity; names and identifying data were excluded from the transcriptions. Their names were etched from the covers of the recordings and replaced with their initials as a means of matching tapes with their respective transcripts. The recordings were transcribed by a person who has no familiarity with the field of mental health nursing or contact with these students. The tapes are stored in a locked cabinet in the researcher's office. The recordings will not be destroyed once the analysis is complete because permission to

use them for on-going educational purposes has been obtained. These are pre-existing data sources made by the researcher for which consent for use for professional development purposes was already obtained. The focus of this research is on elaborating meanings that exist beyond the level of individual intent (Parker, 1992). Therefore, the role of the participants in constructive research is reduced to a minimum (Willig, 2001).

3.7.1.1 Obtaining ethical approval for this study

A proposal for this study was developed and presented to the School of Nursing's research committee. Their recommendations were integrated into the proposal and submitted by my research supervisor to the then University of Natal (Durban) Faculty of Social Sciences and Humanities ethical research committee, for ethical approval. This approval was obtained and a copy of their letter can be found in Appendix H.

3.7.2 Conclusion as the natural history of my research

Silverman believes the lively telling of the "natural history of my research" is an important aspect of qualitative research that serves two purposes (2001, p. 236). The first purpose is to enliven the discussion and in so doing, to draw in the interest of both writer and reader. The second purpose is that of reflexivity. Reflexivity in qualitative research requires that the researcher engage with the intellectual process of research while retaining some degree of awareness of how the researcher's point of view - personal experience, values, interests, knowledge, beliefs, moral qualities - are brought to bear in shaping the form, content and outcome of the research process (Silverman, 2001; Willig, 2001).

If I were to offer a brief natural history of my research, it would probably revolve around the issue of the opaqueness of academic and scholarly writing and in

particular, the extent to which it seems as if the meaning of theoretical concepts is only illuminated once a specific intellectual and emotional pain threshold has been achieved. The problem of course, is that each version has its own threshold. So for example, Gergen's (1999) work in the area of social constructionism and Silverman's (1997; 2001) in the area of discourse and conversational analysis are of a moderate intensity while Fairclough's (1992) work on discourse analysis requires a great deal of stamina. Similarly, the positioning theory work of Harre and van Langenhove (1999) seems at first glance reasonably painless but excruciating in its application.

I encountered a sentence in the authors' introduction to positioning theory that I think illustrates this point: "The grammatical rules for the use of such constructions shows that, for example, in English usage the pronoun I is an indexical locating various aspects of the speech-act it labels with respect to a specific and marked location in the space-temporal manifold of embodied persons and in a variable location in a multitude of manifolds of morally responsible persons, unique in each act" (P. 24). Added to this academic opaqueness is the persistent and pervasive worry about whether what is being done is theoretically sound and above all, meaningful. I was quite relieved to read that "... academic vagueness in rhetoric [language of a specific theoretical perspective] can be a vital means of accomplishing a particular way of doing social sciences."(Billig, 1999, p. 550).

Therefore, the theoretical works underpinning this study were chosen as much for their theoretical fit with the research questions as for my own grasp of them and as for my understanding of what I might be able to do with them.

I was first introduced to Foucault's ideas about discourse by Professor Julianne Cheek (Director for Research, University of South Australia) and thereafter, supported in my development of these ideas for some time, through e-mail correspondence with Dr. Kay Price of the same institution. Later, Professor Jenny Clarence-Fincham (School of Language and Linguistics, Pietermaritzburg Campus,

University of KwaZulu-Natal) introduced me to Fairclough's (1992) ideas about textual analysis. Later still, Professor Kevin Durrheim (School of Psychology, Pietermaritzburg Campus, University of KwaZulu-Natal) introduced me to social constructionism as an epistemological framework and positioning theory as one possible analytic device to use in developing and contextualising one understanding of the doings of these texts. It was from this suggestion onwards that the study began finally to fall into place.

Table 3 ***Summary of topics of talk, the order in which they were raised in talk and the number of exchange sequences associated with each topic***

Topic:	Well being		Medication		Mood symptoms		Psychotic symptoms		Sleeping and eating patterns		Place/people of residence		Financial status/problems		Family		Work patterns		Religion		Recreation		Social relationships		Any worries or issues?		Does taking help?		Next appointment	
Transcript Number	Order	Sequences	Order	Sequences	Order	Sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences	Order	sequences
1	1	2	4	2	0	0	0	0	0	0	2	3	0	0	3	4	0	0	0	0	0	0	0	0	0	0	0	0	5	1
2	1	1	2	4	0	0	0	0	4	12	3	2	0	0	0	0	0	0	0	0	0	0	0	0	3	8	0	0	5	1
3	1	2	6	4	0	0	0	0	2	2	0	0	4	3	5	2	0	0	0	0	0	0	0	0	0	0	0	0	7	1
4	0	0	2	1	0	0	0	0	3	1					4	1									1	1			6	1
			5	1																										
5	1	6	2	14	0	0	3	7							4	3									5	7	0	0	6	1
6	1	3	2	10	9	13	8	2	3	8	0	0	0	0	10	2	0	0	5	1	6	1	7	3	4	11	0	0	13	1
																							11	2	12	2				
7	1	2	7	1	2	7	0	0	4	3	6	2	0	0	9	13	5	2	0	0	0	0	0	0	10	2	3	4	11	2
																	8	2												

Chapter Four

Analysis and Discussion

4.1 Introduction

I have established in chapter two that divergent ontologies inform the contexts within which these texts were generated. On the one hand diagnostic-psychiatry, with its biomedical focus on symptoms and behaviour as normative markers of psychiatric illness and health, underlines the moral order of the clinic. On the other hand, a person-centered approach underlies both the rhetoric of modern psychiatric nursing and the undergraduate psychiatric nursing curriculum of the School of Nursing. Problem solving or at least, a linear, staged approach to care infuses the moral order of speaking of these three contexts.

In the methodology section of 3.5.2.1.1, the analytic devices of text structure description were used to show how student nurse-client talk could be constituted as evolving the agenda of the diagnostic-psychiatry moral order of the clinic (Fairclough, 1992; Gergen, 1999; Potter and Wetherell, 1987; Eckman and Segesten, 1995). It was further established that this psychiatric agenda is constituted around various elements such as physiological patterns (eating well and sleeping well), medication efficacy, functional capabilities at home, at work and in relations with others, financial wellbeing, residential arrangements and family relationships (Horwitz, 2002). I suggested that the kind of watch being kept in these texts resonates with the discursive activities of diagnostic psychiatry and the psychiatric nursing process, namely, the linear, problem-solving activities of examination and assessment, diagnosis or classification, intervention and evaluation (Crowe, 2006; Horwitz, 2002).

4.2 The retrospective gaze of the positioning theory analysis

The following sections will show how the analysis found that, from a positioning theory perspective, student nurse-client talk within the evolving psychiatric agenda potentially works to normalise and/or to resist expressions of client-agency and the person-centred potential of nursing practices, in the direction of the evolving expected psychiatric storyline.

Section 4.3 will show how, from the social act-action pole of the positioning theory triangle, four distinctive discursive activities with specific normalizing effects were defined (sections 4.3), situated within these texts (section 4.3.4) and their workings illuminated in specific excerpts in these texts (4.4). I have termed these discursive speech actions as **highlighting, herding and hectoring.** Within the parameters of the analysis I have used the term **normalizing talk** to describe and to refer to these discursive activities whose effects are to manifest client and nurse speech acts as psychiatric social actions within the context of the nurse-client conversation situated in the moral order of the psychiatric clinic (Gergen, 1999; Horowitz, 2002). The potential for transformative, self-authorising talk - a form of resistance to patterns of normalising talk - is introduced into the texts through the discursive activity of what I have termed **heeding.**

In chapter five, I draw upon some of the ideas of social constructionism to discuss the potential effects of these activities for a person -centred approach to student psychiatric nurse clinical practice. To this end, the ways in which normalisation and resistance/transformation works within the texts may resonate with a post-structuralist understanding of disciplinary power, and to the extent that it does, these ideas will be used to inform the discussion (Smart, 1985).

4.3 First and second order positioning practices in student psychiatric nurse – client talk

4.3.1 Introduction

The following sections attempt to show first, how the four discursive activities of **highlighting, herding, hectoring and heeding** are manifest and unfold in dialogue and secondly how, as positioning practices, they work to normalise and to stabilise the interaction in the direction of the psychiatric surveillance storyline.

These discursive social actions will be defined, illuminated, and discussed with reference to specific conversational cycles in the texts. Fragments of these various discursive activities are deployed throughout the texts and that my illumination of one type in a particular sequence does not mean that other types are not at work in that same sequence. From this perspective, illumination in analysis is a theoretical decision taken by the researcher and not an a priori feature of conversation in the texts (Fairclough, 1999; Gergen, 1999; Holliday, 2002; Fontana, 2004; Willig, 2001). I have also integrated discussion with analysis because each adds to the intelligibility of the other (Fontana, 2004; Willig, 2001).

4.3.2 The first order positioning practice of highlighting defined

I have used the term **highlighting** to describe the social effects of the conversational sequences wherein the subjects of these texts are identified in their respective positions of client and nurse and then unintentionally and/or intentionally progressively manifest as psychiatric nurse and psychiatric client within the unfolding psychiatric storyline (Gergen, 1999; Gilbert, 2002; McHoul and Grace, 1993; Harre and van Langenhove, 1999). The effect of highlighting is to

establish a jointly understood premise for what kind of social meanings (knowledge) are to be generated in dialogue and for how these meanings might be progressively developed, sustained and manifest through the conversational triad of position/storyline/social action (Harre and van Langenhove, 1999).

The discursive activity of highlighting in these texts is a first order positioning practice, jointly accomplished without question, negotiation, or dispute; that it is necessary for the intelligibility of the nurse-client interaction within the psychiatric clinic; that it is first invoked in the introductory moments of these texts and sustained or disrupted in the working and termination phases of these episodes of interaction; and that its disruption provides the necessary context for second order forms of negotiated interaction (Forchuk and Reynolds, 2001; Gergen, 1999; Harre and van Langenhove, 1999). Highlighting is therefore differentiated from herding and hectoring because of its immediate performative and non-contested effects (Harre and van Langenhove, 1999).

4.3.3 The second order positioning practices of herding, hectoring and heeding defined

The second order positioning practices of **herding, hectoring and heeding** are accomplished in these texts through the various ways in which the first order positioning practices of **highlighting** are negotiated and accepted, rejected or re-defined within the on-going to-be-expected psychiatric storyline (van Langenhove and Harre, 1999).

I have used the term **herding** to describe the social effect of the conversational sequences wherein the speakers draw upon the discursive resources of either the psychiatric agenda, the person-centered approach or their personal biographies to shape and to herd the unfolding storyline/speech acts-actions/positions in the direction of the psychiatric agenda and, if necessary, away from that which has the

potential to threaten it (Fairclough, 1992; Gergen, 1999; Harre and van Langenhove, 1999). **Hectoring** is a form of herding but has overt elements of force and coercion associated with it (Harre and van Langenhove, 1999). The effects of **herding and hectoring** are to re-inscribe and normalize the already highlighted psychiatric speaking positions and meanings thereby increasing their visibility and authority in the evolving conversation.

I have used the term **heeding** to describe the social effect of the conversational sequences wherein instances of client-agency (section 3.3.6.3) are manifest and sustained as intelligible actions of self-authorisation in episodes of interaction. There are three distinct ways in which self-authorisation is accomplished in "doing agency" in interaction (Harre, 1989). The first is through referring to one's powers and one's rights to exercise them, the second is through referring to aspects or events in one's biography (reporting on what I did, saw, felt and what happened) and the third is through referring to personal experiences as legitimising certain claims and actions (Harre, 1989).

The extent to which a client's account is manifest and sustained as an act of self-authorisation in conversation is dialogically linked to the extent to which it is persistently attended to as such by the nurse. Thus, the criterial doings for the discursive activity of heeding in psychiatric nursing-talk are two-fold and conditionally related (Gergen, 1999). The first doing evidences the extent to which the nurse's utterances are oriented toward client expressions of self-authorisation. The second and related doing evidences this first doing and the degree to which the client's rights to on-going expressions of self-authorisation are persistently and jointly sustained in the unfolding conversation.

From this perspective, the primary discursive end-point of heeding is sustained expressions of client self-authorisation, an outcome that appears to be consistent with the person-centred theory of psychiatric nursing (Harre, 1989).

4.3.4 The location of these practices in the texts

The presence of fragments of heeding, hectoring, herding or highlighting within the texts is not sufficient evidence for a positioning practice. From a positioning theory perspective, the extent to which a particular discursive activity is manifest in dialogue is dialogically related to the extent to which it is taken up as one or the other and attended to and sustained by both speakers (Gergen, 1999; Harre and van Langenhove, 1999). Table 5 shows the locations of these activities in each of the texts. This table suggests that highlighting occurs most frequently in these texts (in 35 out of the 52 sequences), followed by herding (12 out of the 52) and then hectoring (in 5 out of the 52).

Table 5: ***Presence and location of the discursive positioning practices within the conversational sequences of each text***

Text: / Sequence	1	2	3	4	5	6	7
1	Highlight	Highlight	Highlight	Highlight	Highlight	Herding	Highlight
2	Highlight	Herding	Highlight	Highlight	Herding	Hectoring	Herding
3	Highlight	Herding	Highlight	Highlight	Herding	Herding	Hectoring
4	Highlight	Hectoring	Highlight	Highlight	Highlight	Hectoring	Herding
5	Highlight	Highlight	Highlight	Highlight	Highlight	Highlight	Herding
6			Highlight	Highlight	Highlight	Highlight	Highlight
7			Highlight			Highlight	Highlight
8						Herding	Highlight
9						Herding	Hectoring
10						Highlighting	Herding
11						Highlight	Highlight
12						Highlight	

Subsequent sections will talk directly to these activities and their locations. While there are fragments of the first criterion of heeding in the texts (and these have been identified as open or close ended feeling statements in the transcription process in section 3.5.1.3), there is little textual evidence for their sustained presence as meaningful social actions in the unfolding dialogue.

4.3.5 The discursive end-point of the doings of student psychiatric nurse-client talk in these texts

The subsequent sections will show how the analysis found that the discursive activities of talk - highlighting, herding, hectoring and heeding - work with varying degrees of deliberateness to re-constitute the social meaning of the client speakers' utterances as **to be expected** (my emphasis), that is, as likely to happen and therefore normative, given the ontology of diagnostic-psychiatry which considers all of life experiences as potential signs and symptoms of psychiatric status (Horwitz, 2002). The to be expected social meaning is jointly accomplished and sustained in these texts through the various discursive ways in which the to be expected psychiatric storyline or meaning is systematically woven into and/or coaxed from the developing psychiatric agenda.

The first broad marker of accomplishment is visible in the way in which the different threads or topics (see section 3.5.2.1.1 for a review of the topics of talk identified in these texts) of the psychiatric agenda such as well-being, medication, family relations, sleeping and eating patterns are introduced and sustained in these textual episodes of interaction. Within these texts, each topic is individually highlighted and its constituent elements separated out and examined for their potential consistency and/or inconsistency with the psychiatric agenda. These meanings are then progressively worked back into the broader to be expected psychiatric storyline as markers of a psychiatric evaluation and the completion of the interview.

The second broad marker of achievement is visible in the way in which the nurse-speakers draw upon different resources - their personal biographies, narratives of coping and the psychiatric agenda - to highlight and to herd and if necessary, to coerce client-speakers to account for difficult daily life experiences as examples of coping and therefore, as markers of overall functional improvement, rather than as specific needs or health responses to be addressed. Metaphors commonly associated with the activity of herding – of inducing movement in another from one point to a specific end-point using collaborative or coercive means - will be used to illuminate how positioning/social action/storyline practices of the same and different orders might unfold in dialogue to produce this normalising, to be expected effect and end-point.

4.4 Textual analysis of first order positioning practices in student psychiatric nurse-client talk

4.4.1 The social action and positioning practices of highlighting

The following analysis will illuminate highlighting as an activity in these texts and then show how it works first to locate the interaction within the ambit of the diagnostic psychiatry moral order of the clinic and then to illuminate and to fix the speakers within their respective institutional positions of accounting or reporting psychiatric client and observing, surveilling psychiatric nurse (Moghaddam, 1999).

Although highlighting is integral to the practices of herding, hectoring and heeding, it is most obviously visible in two places in these texts (see Table 5): in the introductory sequences of all but transcript six, in the termination sequences of all the texts and in the middle phases of transcripts one, three, four and five. Some of these instances will be used to show how the *to-be-expected* social

actions/psychiatric storyline/positions are first illuminated and then fixed and followed, without dispute, in the unfolding student psychiatric nurse-client dialogue.

In these next excerpts (5-11) of highlighting in section 4.4.1.1, the speakers are highlighted in their introductory positions of inquiring nurse and accounting client. The final excerpt (12) in 4.4.1.2 illustrates how these positions are redefined as psychiatric inquiring nurse and psychiatric accounting client. The final section of highlighting (4.4.1.3) shows how these positions are reinforced in the closing sequences of these episodes through granting access to medication – the oracular tool of diagnostic psychiatry (Mehan, 1999).

4.4.1.1 Social action of inquiring/reporting in highlighting

> *"So then how have you been doing in the last month?"/"Fine, much better"* (Transcript 1 Appendix A, lines 1-2)

Each episode of interaction opens with an introductory nurse-client exchange, all of which are illustrated below. An agreeable, non-challenging atmosphere characterizes these introductory sequences. The relative lack of speech pauses, hesitancy markers (.) and the use of uncontested phrases to describe wellbeing (such as eating well, sleeping well, doing well on medication) in these sequences suggest that a common understanding about "what is happening here" and "how we will go on together" is being developed (Gergen, 1999). Mishler (1984) and Silverman (2001) point out that this kind of agreeableness and accommodation around a shared ontology is characteristic of routine and ordinary counselling and /or medical interviews.

The performative force of these introductory sequences is explicit and unequivocal. The speakers are positioning themselves and each other as 'inquiring nurse' and 'reporting client' within a developing to-be-expected storyline of well-

being over time (excerpt 5 lines 1 to 3; excerpt 6 line 1; excerpt 7 lines 1-4; excerpt 8 lines 1-3); of problems over time (excerpt 9 line 1); and of well-ness as an effect of medication (excerpt 10 lines 1-5 and excerpt 11 lines 9-16)(Harre, 1999).

Excerpt 5: Inquiring/Reporting (Transcript 1 Appendix A lines 1-7)

1	1.1	Q	Nurse: ((OIS))	How have you been doing ***during the last*** month?
2		A	Client:	I've been fine (.) much better.
3	1.2	PRaeq	Nurse: ((CIS))	Much better? ((Pages being turned)) Mm:: (1 sc).
4		A	Client:	I'm eating well (.) I'm sleeping well.
5				
6	2.1	PRaQ	Nurse: ((CIS))	Sleeping well? (.5) Okay (.5) and (.) at home?
7				(Pages being turned))=***Where do you stay?***

Excerpt 6: Inquiring/Reporting (Transcript 2 Appendix B lines 1-3)

1	1.1	Q	Nurse: ((OIS))	S::o then how are you ***today?*** (Client:Okay) (.)
2				then is there anything you want to ***talk about?***
3		A	Client:	(.5) Not really sister.

Excerpt 7: Inquiring/Reporting (Transcript 3 Appendix C lines 1-10)

1	1.1	Q	Nurse: ((OIS))	You look so nice Mr ((X)). ***How can I help you?***
2		A	Client:	Umm:: I'm here for my tablets. nurse=
3	1.2	Preq	Nurse: ((OIS))	=How have you being ***doing in the last month?***
4		A	Client:	O:h (.) Pretty well. I was feeling much better
5				[Nurse:Coughs] (.) especially with the [Nurse:
6				Coughs]tablets.
7				
8	2.1		Nurse: ((OIS))	How are your ***sleeping patterns (.5) and_eating*** also
9				(.5) comparing to prior to your
10				((medication))?

Excerpt 8: Inquiring/Reporting (Transcript 6 Appendix F lines 1-9)

1	1.1	Q	Nurse: ((OIS))	***How are you*** ((today?)
2		A	Client:	I'm feeling ((coughs)) feeling okay.
3	1.2	PReq	Nurse: ((OIS))	You're feeling oka::y?
4		A	Client:	A bit tired (.) but (.) but that's:: my age (.) I'm
5				Getting older, you know ((laughs)).
6	1.3	PReq	Nurse: ((CIS))	Are you tired e:very morning or (.) every day?
7		A	Client:	Uh (.6) No (.) no:: I get (.) <u>energy</u> you know but
8				m (.) I'm almost 65 (.) at retirement age now so
9				((laughs)) I get tired (.) you know.

Excerpt 9: Inquiring/Reporting (Transcript 4 Appendix D lines 1-2)

1	1.1	Q	Nurse: (OIS))	Okay (.) ***any issue of concern*** that concerns you?
2		A	Client:	Nothing=

Excerpt 10: Inquiring/Reporting (Transcript 5 Appendix E lines 1-10)

1	1.1	Q	Nurse: ((OIS))	***How have you been[***
2		A	Client:	[I'm alright. When I take the
3				tablets I'm fine.
4	1.2	PRaeq	Nurse: ((OIS))	Is it? If you don't take your tablets what's[
5		A	Client:	[If I don't
6				take the tablets then I (.) I (.) I be'naggy' [Nurse:
7				Naggy, what's?] (.) like (.) you know (.5)like (.)
8				especially with my wife, you know (.) I say you didn't
9				do this you didn't do that[
10	1.3	PReq	Nurse: ((CIS))	[You argue a lot?

Excerpt 11: Inquiring/Reporting (Transcript 7 Appendix G lines 9-16)

9	1.1	Q	Nurse: ((OIS))	*How are you this morning*?
10		A	Client:	Ja, okay. I am feeling a bit better with the
11				medication.
12	1.2	Praeq	Nurse: ((CIS))	((10 sec) Cell phone ringing: nurses laughing:
13				Papers shuffling)) So you're saying you're
14				feeling much ((Client:Better, yes) better since
15				you've been on[
16		A	Client:	[Better, Yes.

In these introductory sequences particular discursive threads are being drawn into the to-be-expected psychiatric storyline that have consequences for how the activity of highlighting is introduced within these introductory "how are you" exchange sequences. The interwoven threads are of those of the purpose of talk; the agenda for talk and a shared history of relationship (see section 3.5.2.1.1 and section 4.3 of this chapter).

Talk as the medium of assistance is implicitly established across all the texts in the *"how are you/how have you been"*, and explicitly in the nurse speakers utterances in excerpt 6 line 2 *"is there anything you want to talk about"* and in excerpt 9 line 1 *"any issue of concern that concerns you"'*. Both the interpersonal psychiatric nursing and the diagnostic-psychiatry mandates regard talk as their primary means of assistance and the medium through which knowing the other, is accomplished. Whereas the nursing mandate argues that it is through talk that the meanings inhered in the intangibles of feeling and experience are made known to self and to others, the medical mandate uses talk to confirm or disconfirm specific bodily experiences as signs and symptoms related to its field of knowledge (Forchuk and Reynolds, 2001; Hagerty and Patusky, 2003; Horwitz, 2002). Knowledge about the self and other is therefore an anticipated outcome of talking while what is spoken about (agenda) constitutes how the speakers are made known to each other through talk (Cameron, 2004; Gergen, 1999; Mishler, 1984; Roberts, 2004).

It is possible to construe the nurse-speakers broad and open-ended "how are you" as exemplars of the person-centered nursing mandate because of its potential to call forth the whole person (Cameron, 2004). However, from a positioning theory perspective, the extent to which 'how are you' is manifest as a person-centered moment depends upon the extent to which it is taken up, attended to and sustained as such by both the participants (Harre and van Langenhove, 1999). In these previous excerpts, the nurse-speakers opening question how are you manifests as "provide an account of your psychiatric improvement in biological, physical, medication and

social terms" not only because of its psychiatric situatedness but also because it is taken up as such and without negotiation, in the client-speakers answers and subsequent nurse-speakers elaboration questions (Gergen, 1999; Harre and van Langenhove, 1999).

Thus, a particular understanding of "being over the last month" as a biological rather than a holistic (feeling, experience, activity) event is being progressively developed and attended to by both speakers in these introductory sequences. For example, the client-speaker in excerpt 5 (line 4) uses the physical categories of eating well and sleeping well to denote psychiatric wellness while the client-speakers in excerpts 7, 10 and 11 invoke medication as a marker of wellness. The frequent repetition of the words *"fine"*, *"Okay"* and *"better"* as a marker of "how I am" further suggests that a trajectory of improvement is being woven into the biological well-being storyline. How *"better"* as an aspect of wellness is constructed and measured in dialogue, will be explored further as an aspect of the discursive activity of herding in the following section. This biological understanding of "being over the past month" is similarly taken up in the nurse-speakers utterances.

For example, in excerpt 5 the nurse-speaker introduces the topic of living arrangements (lines 6-7) in response to the client-speaker's previous explanation of eating and sleeping well as a gauge of being `much better' (line 4). The nurse-speaker's repetition of the client-phrase *sleeping well?*, (line 6) the in agreement effect of the word *"Okay"* punctuated by two small pauses (.), and the introduction of the new topic *"...and [things] at home?"* suggests that sleeping well and eating well are required and to-be-expected markers of `better' and that the surfacing of this meaning marks the completion of the "how are you" question-answer exchange cycle and the beginning of the next (Fairclough, 1992; Silverman, 1997 and 2001).

In these excerpts, both speakers are using the discursive resource of psychiatric assessment and treatment to account and to call each other to account for the intelligibility of their utterances from within the diagnostic-psychiatry moral

order of speaking (Fairclough, 1992; Gergen, 1999; Horwitz, 2002). To this end, both speakers are unintentionally (and perhaps, intentionally) positioning themselves and each other, as representatives of the psychiatric moral order (Harre and van Langenhove, 1999). However, it is also clear that the speakers are asymmetrically positioned with respect to the kind of voice with which they are entitled to speak within this disciplinary space (Fairclough, 1992). Whereas the nurse-speakers are authorized to initiate and to terminate the exchange cycles and thus, to speak from the position of psychiatric judge or arbiter, the client-speakers are allocated the position of recipient of care, authorized to answer questions about their well-being with concrete, behavioural responses and illustrations – *I am fine when I take the tablets; I have nothing to talk about; I am eating well and sleeping well* (Irving et. al., 2006; Latvala, Janhonen and Wahlberg, 1999; Latvala, 2002; Parker, 1992; Roberts, 2004).

The idea that both speakers draw upon the discursive resources of the moral order of diagnostic psychiatry to bring intelligibility to the nurse-client interaction is not to suggest that meaning in the interaction is institutionally directed and beyond the purview of the individual participants (Gergen, 1999). The social constructionist idea that joint attention to individual intent manifests its social meaning is illustrated in excerpt 12. The introductory sequence in this excerpt differs from the others in that there is an element of discord in the tone of the sequence.

Excerpt12: Individual intent/manifest meaning (Transcript 6 Appendix F lines1-9)

1	1.1	Q	Nurse: ((OIS))	***How are you*** **((today?)**
2		A	Client:	I'm feeling **((coughs))** feeling okay.
3	1.2	PReq	Nurse: ((OIS))	You're feeling okay?
4		A	Client:	A bit tired (.) but (.) but that's my age (.) I'm
5				Getting older, you know ((laughs)).
6	1.3	PReq	Nurse: ((CIS))	Are you tired every morning or (.) every day?
7		A	Client:	Uh (.5) **No** (.) no: I get (.) energy you know but
8				m (.) I'm **alm**ost 65 (.) at retirement age now so
9				((laughs)) I get tired (.) you know.

In this sequence, the client-speaker uses the resources of his personal biography and a touch of humour *"A bit tired but that's my age I'm getting older you*

know" to account for his well being (lines 4-5). The nurse-speakers elaboration question *"Are you tired every morning or every day?"* in line 6 by-passes the personalized aspect of the client's response, thus making the speaking positions of reporting psychiatric client and inquiring psychiatric nurse more visible within the interaction. However, the client-speakers subsequent utterances overturn these allocated positions and his humorous repetition of the relationship between age and tiredness (lines 7- 9) create the possibility for more equitable, person-focussed speaking positions.

Whereas the kind of meaning being developed in the other sequences is jointly and immediately manifest as psychiatric meaning, there is an element of struggle for visibility of versions of meaning – personalized or psychiatric – between the speakers in excerpt 12 (Mishler, 1984). Does the nurse-speaker take up or reject the equitable, person-focussed speaking positions offered in the client-speakers utterances? Negotiation and struggle are aspects of second order positioning practices that is discussed further in the following section. Its presence is raised here to illustrate the point that individual intent to infer a particular kind of meaning is not the only criterion for meaning to manifest in dialogue (Gergen, 1999; Harre and van Langenhove, 1999).

The discursive activity of highlighting is jointly begun in these introductory sequences. At issue here is not whether the speakers are being highlighted or not but rather, what kind of nurse and client subject positions are being made available or visible for the speakers to take up, and with what effect for their going on together? Cameron (2004) suggests that these introductory nurse-client moments are quintessentially ethical because they open up possibilities for relational involvement wherein the whole person may be attended to or dismissed. This ethical understanding is reflected in the modern mandate of psychiatric nursing which asserts that the psychiatric nurse is morally obliged to attend to the whole person in each phase of the nurse-client relationship and to initiate and to sustain this focus,

irrespective of context (Cameron, 2004; Hopton, 1997; Littlejohn, 2003; Roberts, 2004).

While person-centered speaking positions are the relational mandate of psychiatric nursing practice, saying so is insufficient to manifest it in practice settings where other speaking positions, such as the institutional positions of knowledgeable, active professional and passive, beneficent client, predominate (Cameron, 2004; Hardin, 2001; Heartfield, 1996; Hopton, 1997; Latvala, 2002). Thus, the potential of the moment to call forth or to dismiss the whole or the body-part client and the person-centred or body-part nurse, is manifest in the jointly constructed effect of the interaction situated in both interpersonal and institutional context (Gergen, 1999).

4.4.1.2 Social action of psychiatric inquiry/psychiatric accounting

"Okay, how are you eating and sleeping /your living arrangements / your finances/your family relations /your tablets?"/"Fine"

The first order, performative effects of the conversational cycles in these texts are immediately obvious: questions are asked and accounts are given (Gergen, 1999). The conversational cycles unfold relatively smoothly along the mutually familiar topics of the to-be-expected psychiatric storyline. I have already made the case for the weighty presence of the psychiatric agenda within each of these texts (see chapter three, section 3.5.2.1.1). I have shown that the question-answer information seeking exchange structure - characteristic of medical and counselling interviewing - predominates in these texts with 98% of these exchanges being opened and closed by the nurse-speaker (Mishler, 1984; Silverman, 2001).

I have also shown that the conversational topics around which these cycles are deployed are characteristic of the diagnostic-psychiatry mandate and finally, that the most frequently talked about topics in these texts in descending order of frequency

are: well being over the past month, medication efficacy and the details of the next appointment, family relations, sleeping and eating patterns and an invitation to talk about other worries, living arrangements, the presence of mood and psychotic symptoms, financial concerns, recreational pursuits, religious support, social relationships, work patterns and an invitation to talk about whether talking helps (Horwitz, 2002).

The respective speaking positions of inquiring nurse and accounting client already developed in the introductory sequences are further inscribed as the to-be-expected psychiatric meaning unfolds in dialogue. Excerpts from transcripts three and four will be used to illustrate how highlighting (positions/speech acts) progressively opens out along and constitutes the psychiatric storyline.

Excerpt 13 (taken from transcript 4) illustrates how the basic topics of the psychiatric agenda are accomplished through all six (6) nurse-initiated question-answer exchange cycles. Information seeking predominates in these exchanges with two examples of information-delivery. The nurse-speaker draws on these information-seeking, question-answer discursive mechanisms of interviewing to elicit key information and particular descriptions - problems (line 1), medication (lines 3 and 4), sleeping and eating patterns (line 7), wellbeing of husband (line 10), reason for being at the clinic (line 13) - about the client-speakers functional status (Fairclough (1992).

That the nurse-speaker uses the client-speaker's monosyllabic but definitive answer *"yes"* (in almost all the exchange sequences) to terminate one topic of exchange and to initiate the next, suggests that this monosyllabic response is regarded as sufficient for an evaluation of the client-speakers functional abilities within each of these topics.

Excerpt 13: Psychiatric inquiry/psychiatric accounting (Transcript 4 Appendix D Lines 1-27)

1	1.1	Q	Nurse: (OIS))	Okay (.) *any issue of concern* that concerns you?
2		A	Client:	Nothing=
3	2.1	PRaQ	Nurse: ((CIS))	Okay (.5) are you still (.) doing well with your
4				**medication?**
5		A	Client:	Yes.
6				
7	3.1	Prq	Nurse: ((CIS)	**Sleeping well, eating well?**
8		A	Client:	Yes.
9				
10	4.1	PraQ	Nurse: ((OIS))	Okay (.) How is **your husband now?**=
11		A	Client:	=He's alright (.) alright.
12				
13	5.1	PraQ	Nurse: ((CIS))	Okay (.5) **then you came for your medication?**=
14		A	Client:	=Yes
15				
16	5.2	PRaID	Nurse: ((ID))	(3 sec) Okay (.5) you must (.) continue taking your
17				medication well (.) so that (.) it will help you (Client:Ja)
18				so you will no longer have any other
19				problems, oka::y?=
20		A	Client:	=Yes.
21				
22	6.1	PRaID	Nurse: ((ID))	=Okay, I'm going to check (.) your date for *your*
23				*Next visit*. It will be on 15th of next month (.) that
24				is April.(Client: Okay.) Okay thanks See you next
25				time. You can go and take your medication bye-
26				bye.
27		A	Client:	Thank you.

Although both speakers within this excerpt are illuminated within the ambit of the psychiatric gaze, their respective speaking positions of inquiring nurse and accounting client are differentially authorised within the gaze. Whereas the nurse-speaker is authorised to elicit, to receive, to question and to evaluate client accounts of psychiatric well-being, the client-speaker is morally obliged to provide a clear and

particular accounting of his/her general and psychiatric well-being, and in this case, a monosyllabic but definitive account is considered adequate (Fairclough, 1992; Gergen, 1999; Harre and van Langenhove, 1999).

There is however, a subliminal glitch in the smoothness with which highlighting as a first order positioning practice is accomplished in this excerpt but which can not be said to have achieved the status of second order talk. I would suggest that this discursive glitch illustrates the performative and normalising effects of first order positioning talk wherein the speakers-in-dialogue and the moral order collaborate – perhaps asymmetrically - to sustain this kind of talk as a routine and unproblematic way of doing psychiatric nursing.

Fairclough (1992) has suggested that monosyllabic responses from less powerful speaking positions in tightly controlled talking contexts might be a form of resistance to the normalising effects of the talk in that context. It is possible therefore, that the client-speaker's monosyllabic reports in lines 2, 5,8,11,14, 20 and 27 (excerpt 13) may be regarded as a form of resistance to the normalising effects of the psychiatric agenda where, from the speaking position of accounting in a specific way to a higher authority, the less said the better (Fairclough, 1992). The nurse-speaker initiated question-answer exchange sequences suggests that these monosyllabic accounts, together with their suggestion of resistance to the kind of meaning being generated about the client, is adequate for an evaluation of the client-speaker's general functioning.

However, the nurse-speaker's utterances in the penultimate exchange cycle (lines 16-18) suggest that while close ended information-seeking questions and their adjacent monosyllabic client-responses are acceptable for a general evaluation of wellbeing, these discursive mechanisms are insufficient to mobilise and to conclude the definitive authority of the psychiatric agenda – the control of the issuing of medication. The exercise of this final act requires an unambiguous acknowledgement and acceptance from both speakers, of its all-encompassing

authority in the pursuit of psychiatric wellbeing. This unambiguous acknowledgement/acceptance is given by both speakers in cycle 5, lines 16-20.

Here, the discursive effects of the nurse-speaker's three second pause (line 16) following on the client-speaker's confirmation of medication as the reason for being at the clinic (line 13-14), the command words *"you must"* (line 16) linking medication as the cause *"continue taking your medication well"* (line 16 and 17) with the effect of being problem-free in the present and the future *"so you will no longer have any other problems"* (lines 18 and 19) are to firmly inscribe diagnostic-psychiatry as the key device for understanding the experiences of daily life and for how nurse-client talk is accomplished in this episode of psychiatric nursing practice.

Within the context of this acknowledgement/acceptance speech act, the potential for resistance in the client-speaker's monosyllabic response in line 20 has been subverted as beside the point: the mandate of the psychiatric clinic has been successfully accomplished. Specific bodily experiences have been confirmed and/or disconfirmed as discipline-specific signs and symptoms and further talk is therefore unnecessary (Hagerty and Patusky, 2003; Horwitz, 2002; Forchuk and Reynolds, 2001; Smart, 1985). The effect of this silencing of both speakers is to further fix them in their respective asymmetrical speaking positions of evaluating, instructing nurse and of accounting, compliant patient.

4.4.1.3 Social action of life world inquiring/psychiatric accounting

> *"You look so nice Mr. X, how can I help you?"/ " Umm:: I am here for my tablets, nurse"* (Transcript 3 Appendix C lines 1-9.)

Harre and van Langenhove (1999) argue that the extent to which the performative, first order effects of talk are sustained in conversation is dialogically

related to a shared history of interaction with specific speaking positions and a familiar storyline. This is largely accomplished through the ways in which both participants use their history of relationships with this agenda to bring an ordered intelligibility to their interaction (Mills, 1997; Silverman, 2001; Smart, 1995).

The history of relationship in this interactional context is manifest, as it is in almost all the transcripts, in the agreeable way in which the interaction unfolds and which suggests it is at least recognizable to the participants and in so being, functions as a resource for both speakers to draw upon (Gergen, 1999; Harre and van Langenhove, 1999; Silverman, 2001).

The client-speaker's response *"Umm:: I'm here for my tablets, nurse="* to the nurse-speakers utterance *"You look so nice, how can I help you?"* (excerpt 14 below, line 1-2) is an exemplar of how the history of relationship serves as a resource for the participants to mutually shape talk and consequently, their respective speaking positions within the evolving to-be-expected psychiatric storyline.

This excerpt and subsequent analysis is presented over the page to facilitate readability.

Excerpt 14: Shared history of relationship (Transcript 3 Appendix C lines 1-10)

1	1.1	Q	Nurse: ((OIS))	You look so nice Mr ((X)). ***How can I help you***?
2		A	Client:	Umm:: I'm here for my tablets, nurse=
3	1.2	Preq	Nurse: ((OIS))	=How have you being ***doing in the last month?***
4		A	Client:	O:h (.) Pretty well. I was feeling much better
5				[Nurse:Coughs] (.) especially with the [Nurse:
6				Coughs]tablets.
7				
8	2.1		Nurse: ((OIS))	How are your ***sleeping patterns (.5) and_eating*** also
9				(.5) comparing to prior to your
10				((medication))?

Given the obvious moral order of speaking within which this interaction is situated, the nurse-speakers comment on the client's appearance and her offer *"how*

can I help you?" introduces the possibility for tension between the institutional principles and practices of the broader moral context and the interactional context (Gergen, 1999). The nurse-speaker's utterances position herself as the dispassionate purveyor of a range (more than one) of psychiatric services from which the client, positioned as consumer with the power to act, may select according to his/her preference. The client's response in line 2 (a lengthened speech sound followed by the purpose for his presence) suggests that the social meaning of the nurse's question, together with the potential for equity in the speaking positions of consumer and provider it creates, is at the very least, **unexpected** [my emphasis] and perhaps, unfamiliar.

The social meaning of the client's utterances in line 2 – **this way of doing is unfamiliar and unexpected** - is taken up and addressed in the nurse-speaker's subsequent speech actions (line 3). Here, the nurse-speaker's post response elaboration question *"how have you been doing in the last month?"* follows without pause (=) on the client-speaker's response in (line 2) and its phrasing resonates with the introductory phrasings of the other transcripts. These two speech features are a consequence of the social meaning - "this is unexpected within this storyline" - being developed in the client's prior utterance (line 2) and have the effect of re-directing the dialogue to familiar ground. This nurse return to the familiar storyline is acknowledged by and is visible in the client-speaker's subsequent *O:h*, and in the short pause (.) which precedes his evaluation of himself as having improved, especially with the tablets (lines 4-6). The potential irregularity – the nurse and client in equitable relations of consumer and provider - in the expected way of doing things in this context has been mutually restored and the to-be-expected psychiatric intelligibility of the interaction and the broader moral context, sustained (Gergen, 1999).

4.4.1.4 Social action of routine closing

"(.) Okay um your next appointment date is..."

Each episode of interaction is terminated around the date for the following clinic appointment. This is hardly surprising, given the context of the interview and that is colloquially termed a "medication interview". What is interesting is the way in which this routine is used to conclude the agenda even in the presence of non-routine life world reports.

All of these exchanges are initiated by the nurse-speaker and, except for transcripts 2, 4 and 5, are either preceded by or integrated with an authoritative formulation about the absence of any other problems or concerns in the client-speaker's life: *"is there anything else you would like to talk about?"*. This formulation is given in these closing sequences in the form of a question requiring an equally authoritative and positive confirmation from the client-speakers. These *"next appointment"* termination sequences are initiated by the nurse-speakers and are in all but transcript 5, taken-up by the client-speakers as agenda accomplishment talk.

Excerpt 15: Routine closing (Transcript 1 Appendix A lines 42-55)

42	4.2	PRaQ	Nurse: ((CIS))	So (.) no set backs (.) nothing ?
43		A	Client:	Well I've had stomach pro::blems but (nothing
44				much).
45				
46	5.1	PRID	Nurse: ((ID))	Okay (3sec) um (.)I'll put you for the ***next***
47				***appointment*** (4sec) and (.5)it should be (public
48				holiday)(3sec) you are comfortable with
49				Wednesday or (.) (Client: Ja, Wednesday) Okay (.)
50				It will be a holiday on Wednesday 1st so it will be
51				Thursday 2nd. (Client: Ja, that's fine(2 secs) 2nd
52				May.) (5sec)That's fine(.) then you can go and get
53				your medication now.
54		A	Client:	Thank you (Nurse: Thank you) Bye (Nurse: Bye.).
55				

Excerpt 16: Closing (Transcript 2 Appendix B lines 116-119)

116	5.1	PRaID	Nurse: ((ID))	Ja (.) I think it might help you (3sec). Anyway,
117				thanks again. ***See you next time***. Then I will
118				write your return date it is on the 23rd of (tape
119				ends)

Excerpt 17: Closing (Transcript 3 Appendix C lines 74-81)

74	7.1	PRaID	Nurse: ((ID))	Okay. your ***next appointment date*** will be 9th
75				October.Is it okay? [Client: It's okay] Do you
76				have ***anything else*** you wanted to talk about?
77		A	Client:	No::: not as yet (.5) nothing.
78	7.2	PRaID	Nurse: ((ID))	Okay (.5) so I think (.) you can wait over there
79				for your tablets.
80		A	Client:	Thank you for your co operation (Nurse: Thank
81				you for your co operation) thank you sister.

Excerpt 18: Closing (Transcript 4 Appendix D lines 22-27)

22	6.1	PRaID	Nurse: ((ID))	=Okay, I'm going to check (.) your date for *your*
23				*Next visit*. It will be on 15th of next month (.) that
24				is April.(Client: Okay.) Okay thanks See you next
25				time. You can go and take your medication bye-
26				bye.
27		A	Client:	Thank you.

Excerpt 19: Closing (Transcript 5 Appendix E lines 252-277)

252	6.1	PraID	Nurse: ((ID))	=Okay (.) Oka::y Okay (.5) uh::(3sec).Your *visit for*
253				*next month* is 24th of the 5th [Client:When's that day]
254				of next month. Okay, here is your medication
255				(.)prescription so you can give it to the sister in the
256				front.(Client:Oh::::okay sister) So:: take it easy now=
257		A	Client:	=Okay (.) you see: when I talk too much (.) then I get
258				too like nervous, don't get (.) ja:: I get too nervous and
259				all (.) you see (.) that is why my daughter gave me
260				one room (.) for me to stay there (.) and she's got
261				magazines and all these things, you know. And I've
262				got some plants (.) everytime I look at (.) you see some

263 people (.) they look at a fish tank (Nurse: Mm) some
264 people look at a fish tank (.) you know they've got a
265 big fish tank in the room (Nurse:Mm) they look at
266 that one (.) and they:: meditate on it. Like I got my
267 plants, now every time a leaf comes out (.)I feel happy
268 (Nurse:Mm) my daughter gave me one room. She
269 stays that side (.) I stay this side (hh) and I've got
270 myself I've got my window if I want to see anything I
271 see, and I've got my plants and all these things.
272 (Nurse: O:::kay) thank-you sister (Nurse: Thank you
273 for talking to me) I'm sorry uh:: to say you (.) I'm a bit
274 upset= (Nurse: No its fine, its okay) because if I talk
275 too much (.5) okay, I hope you understand my
276 sickness Nurse:Okay (.) I understand) Okay then
277 (Nurse: bye, bye.) Tape Ends

Excerpt 20: Closing (Transcript 6 Appendix G lines 281-286)

281	12.1	PraQ	Nurse: ((OIS))	Okay (2sec)and is there ***anything you'd like us***
282				***to discuss?***
283		A	Client:	Uh:: No, not really, we've been through most.
284	12.2	PRaID	Nurse: ((ID))	Mm:: O::kay. Then I'll have to give you a date
285				for ***your next appointment*** (Client: Thanks).
286			Tape ends.	

Excerpt 21: Closing (Transcript 7 Appendix H lines 263-275)

263	10.2	PRaeq	Nurse: ((CIS))	You're fine? (Client: Yes, thanks). So on the
264				whole you are (doing well)?
265		A	Client:	Thanks so much, yes.
266				
267	11.1	PRaID	Nurse: ((ID))	(3 secs) Okay. ***Your doctor's appointment is***
268				***next month.***
269		A	Client:	But I was there last month and I've seen
270				doctor. And, when I see the card, I was also
271				surprised how come I see him so quickly.
272				Because last month I've seen doctor. Because
273				I'm supposed to see him once a month, isn't it?
274	11.2	PRID	Nurse: ((ID))	I don't think its once a month, no, okay then=
275		A	Client:	=Thank-you. Tape ends

The effect of this closing talk is to re-inscribe the speaking positions and to re-enforce the idea that everything talked about thus far, is to be expected – as normal – and therefore, unproblematic. A final opportunity to raise the unexpected is offered in the closing sequences, this raising has the effect of calling for a clear and unambiguous final statement of wellbeing which is a requirement for the entrance to the end-point of diagnostic psychiatry – the issuing of medication.

4.4.1.5 Positioning in highlighting

In this section, a particular kind of knowledge about the client and the nurse in interaction is jointly manifest through the discursive, first order positioning practice of highlighting. Both speakers draw upon the ontology of diagnostic psychiatry and their shared history of relationship as agents of the moral order to inform their speaking positions and in so doing, bring a psychiatric intelligibility to the interaction. These exchange sequences in section 4.4 are exemplars of first order positioning in the extent to which the conversational positions of inquiring psychiatric nurse and reporting psychiatric client are allocated each speaker, inscribed without contest and taken-for granted as "this is the way we are going to do and to complete this interaction" within the evolving psychiatric surveillance storyline (Boutain, 1999; Gergen, 1999; Harre and van Langenhove, 1999).

Clearly, the first order discursive positioning practice of highlighting and the asymmetrical speaking positions it enables have implications for a psychiatric nursing that considers person-centred practices to be its primary mandate for care. Well-being in these introductory sequences has been characterized as a biological phenomenon and as the outcome of psychiatric medication. Communication between the speakers in these sequences has a detached, outcome-oriented and surveilling atmosphere and seems more firmly attached to the instrumental rationality of diagnostic-psychiatry rather than to the reflexive, value-orientation of

nursing, discussed briefly in chapter two (Hyde, Treacy, Scott, Butler, Drennan, Irving, Byrne, MacNeela and Hanrahan, 2005). While the work of nursing draws upon both instrumental rationality and value-oriented dialogue, the former rather than the latter predominates in these sequences.

The person-centered psychiatric nursing talk - reverberating with the discourses of empowerment, partnership, participation and mutual collaboration - is absent from these introductory excerpts. The kind of talk thus far being manifest is health as biology-centered talk, and in the case of these excerpts, as a question-answer dialogue, arranged around a discrete set of topics drawn from the field of diagnostic-psychiatry. The idea that psychiatric nursing talk in these texts is illuminated as a psychiatric rather than a person-centered discursive activity is consistent with the moral order of the clinic within which it is located. In the case of these texts, both speakers draw upon the moral order of the clinic – albeit asymmetrically - to make their speech acts intelligible within the unfolding dialogue.

The analysis in section 4.4.1.3 suggests what might happen in dialogue when client-oriented talk (or any other) is pursued without attention to the moral context and to the speaker's history with that context. In this excerpt, the client-speaker draws upon his history of relationship with the accomplishment of the agenda - medication – to explain his presence at the clinic and in so doing, calls the nurse to account for her subsequent talk from within this, rather than any other perspective.

A constructionist understanding of talk in context will create possibilities for a balanced and diverse understanding of what it is that psychiatric nursing does in talk and thus, extend ideas about psychiatric nursing beyond the confines of the person-centred nursing and psychiatric paradigms. These ideas are developed further in chapter 5.

4.5 Textual analysis of second order positioning practices in student nurse-psychiatric client talk

4.5.1 Introduction

Harre and van Langenhove (1999) suggest that the shared history of relationship through which patterns of talk are made intelligible as first order positioning acts provide both the context and the conditions for their disruption as intelligible social acts. Any break in commonly understood patterns of talk threatens or subverts both the intelligibility of the way of doing and the moral order into which they are woven (Gergen, 1999).

Gergen (1999) believes that the primary functions of second order talk in conversation is to maintain, to restore or to develop a set of common understandings in order for the conversation to have coherence and meaning for the participants. Second order positioning talk is therefore intentional talk with explanatory effects directed towards sustaining the intelligibility of the conversation (Fairclough, 1992; van Langenhove and Harre, 1999).

What happens when instances of dialogue in these texts seem to stray from the normal, to-be-expected path? Gergen (1999) argues that relationships are subject to a centripetal force, that is, to a tendency for communication practices to become singular and routine in an effort to sustain interactional connectedness within the context in which they are located. To this end, specific social meanings with specific speaking positions are deliberately and sometimes forcefully created in dialogue for their potential centripetal or normalising effects (Fairclough, 1999; Gergen, 1992; Haber, 1994; McHoul and Grace, 1993).

The effect of herding and hectoring is to normalize talk in the direction of the 'to be expected' psychiatric storyline of the psychiatric clinic moral order of speaking.

A description of this end-point has been given in section 4.3.5 and illuminated as an effect of highlighting in the previous section. This same end-point is manifest as herding and then hectoring in those conversational cycles where there is evidence of struggle for what social meanings are being jointly developed.

The activities of herding, hectoring and heeding have already been defined in section 4.3.3. Hereafter, textual examples will be used to show how the coercive effects of herding and hectoring are developed and manifest in these texts as activities of student psychiatric nurse–psychiatric client talk with particular effects for their going on together in conditions of relationship (Gergen, 1999).

Table 6 shows the position of these discursive actions within the conversational sequences of the texts.

Table 6: Location of herding and hectoring within the texts

Text: / Sequence	1	2	3	4	5	6	7
1						Herding	
2		Herding			Herding	Hectoring	Herding
3		Herding			Herding	Herding	Hectoring
4		Hectoring				Hectoring	Herding
5							Herding
6							
7							
8						Herding	
9						Herding	Hectoring
10							Herding
11							
12							

Herding is illuminated in sequence two and three of transcript 2, in sequence three of transcript 5, in sequence one, three, six and nine of transcript 6 and in sequence two and five of transcript 7. Hectoring is illuminated in the fourth sequence of transcript 2, in the second, fifth and tenth sequence of transcript 6 and in the third and ninth sequence of transcript 7. Many of the cycles in these texts are exemplars of how highlighting may manifest as herding and then in hectoring when one or the other or both speakers stray off the 'to be expected' or normal path.

4.5.2 The social actions and positioning practices of herding and hectoring illuminated

I have already suggested that the analysis shows that the discursive practices of highlighting, herding and hectoring are to normalize on-going talk in the direction of the 'to-be-expected' psychiatric storyline. Whereas the normalising effects of this talk are uncontested in the social action of highlighting, herding and hectoring are defined and differentiated with respect to the degree of struggle for the kind of social meaning being generated and attended to in the unfolding dialogue.

The coercive effect of herding and hectoring is to decontaminate the evolving talk. By decontaminate, I mean the extent to which client-authored statements are called forth and examined for their personal, life-world meanings and then systematically expunged of these meanings and re-constituted with various degrees of force, as normative markers of the absence of psychiatric problems, of the efficacy of medication and paradoxically, of the helping effect of talking. The following excerpts illustrate how this analysis unfolds this discursive process.

4.5.2.1 Herding: Social actions and positions illuminated

4.5.2.1.1 The social action of persuading/deferring distress in the direction of normative well-being

"Otherwise (anyway), everything is okay/fine?"

The 'to be expected' social meaning is jointly accomplished in the words *"otherwise"*, *"anyway"* which are usually linked to the phrase *"everything is okay/fine?"* Although the phrase *"otherwise"* only appears a few times in these texts, the meaning of the phrase succinctly captures what I understand to be the overall and jointly developed decontaminating effect of herding along the normal path, manifest in these episodes of interaction. The words *otherwise* and *anyway* are generally used to signify the surfacing of something other than what is expected, that is, something other than is typical for the situation or event. The phrase *"otherwise"* appears in Transcript One (Appendix A) line 36 and in Transcript Two (Appendix B) lines 65 and 67 from where excerpt 22 is taken.

This excerpt illustrates how the word *otherwise* is used by both speakers (lines 65 and 67) to simultaneously close an avenue of dialogue and to normalize the effects of the preceding talk in the direction of the to-be-expected storyline. The sequence 3.1 opens in line 27 with the nurse asking the client if she has anything troubling her.

The client-speaker responds first in the negative (line 29) and then, following the nurse-speaker's continuing utterance: *Mm::*(line 29), offers a personalized account of her tension headaches, of her understanding of the causes of these headaches as social rather than medical, of their relationship to her problems with her boyfriend, her little boy and of her not having but wanting a place of her own to live.

These expressions are punctuated with largely medicalised inquiries from the nurse-speaker about whether the client has sought medical help for her headaches

(lines 31-32) and specifically, from a general hospital (lines 35 to 37), with concrete expressions of problem identification (lines 45 and 56) and with a feeling-focussed question (lines 48-49).

The nurse-speaker's penultimate utterance in lines 61 and 62 *"anyway, is it better now?"* together with the speech hesitancy markers, pauses and tonal emphasis on the *"<u>better now</u>"* introduces a cautionary note to the dialogue. Whereas everyday life experiences may be subsumed within the ontology of diagnostic-psychiatry, they are to be used to illustrate points of functional improvement and/or impairment rather than as experiences to be explored for their own worth and meaning (Horwitz, 2002).

The nurse-speaker's use of the words *anyway* (line 61) and *otherwise* (in line 65) in response to the client's life-world experiences, suggest that these experiences are to be expected within the gamut of daily life but are not exceptional or visible enough within the context of the psychiatric world to mobilize a helping initiative.

Excerpt 22: Persuading/deferring (Transcript 2 Appendix B lines 27-67)

27	3.1	PRaQ	Nurse: {{CIS}}	Okay ((Laughs softly)):: (.) so:: (.) is there anything
28				**that is troubling you?**
29		A	Client:	(.5) Not really (Nurse: Mm::) I suffer with my
30				head as well.
31	3.2	PReq	Nurse: ((CIS))	And then (.) did you see your doctor about
32				that?
33		A	Client:	(1 sec) N::o (.) I didn't see the doctor for this I
34				suffer with tension.
35	3.3	PRaeq	Nurse: ((CIS))	Mm: (.) so then have you ever went to (names
36				General hospital)) because the Doctor might not
37				help you here=
38		A	Client:	=I've <u>never been to a hospital</u>. I normally buy
39				the tablets from the::: (.5) this thing (.) surgery
40				across from my place. I buy the tablets and I

41				**uhh. I normally buy pain tablets (.)but it doesn't**
42				**seem to be helping.** You=s::ee I have a little boy
43				and (.) um (.) my boy friend (.5) and you know (.)
44				he gives me problems now and again too.
45	3.4	PReq	Nurse: ((OIS))	What problems (.) what problems does he give?
46		A	Client:	(.5) He's always (.) like (.) fighting and arguing
47				(.) and stuff like that.
48	3.5	PRaeq	Nurse: ((OF))	With you? And then (.) how does that make
49				you feel?
50		A	Client:	(4sec) I told him that if he, he wants to be
51				separated, he is welcome to do so because I'm
52				ay:: (.) I'm one person that (.hh) I can't stand
53				nonsense. (Nurse: Mm::hh) That is why I
54				suffer with my head [Nurse: What did he say?]
55				it's the tension=
56	3.6	PReq	Nurse: ((OIS))	=What did he say then?
57		A	Client:	Mm:: (.) he doesn't wanna say anything, he
58				doesn't want to leave me (Nurse: Mm::) (.2)
59				You s::ee I'm living with my aunty (Nurse: Ja)
60				I don't have a place (.) of my own.
61	3.7	PRaeq	Nurse: ((CIS))	Mmm:: (2 sec) So:: (3sec) Anyway. (.5) Is it
62				better now?
63		A	Client:	(3sec) Ja, .hhh ((laughs softly)) it is but I would
64				prefer a place of my own=
65	3.8	PRaQ	Nurse: ((CIS))	=Ja (2sec) I understand. So you say otherwise
66				there isn't anything that's troubling you?
67		A	Client:	Otherwise, no.

This cautionary note is manifest in the extent to which the client speaker's subsequent response *"it is but I would prefer a place of my own"* (line 63-64) is preceded by a three second pause, a hesitancy speech marker and a soft laugh. These response speech features, together with the word *prefer*, have two simultaneous effects within the herding toward the 'to be expected' end-point of the psychiatric storyline. The first effect is of diminishing and marginalizing the personalized certainty and intensity of the client-speaker's previous life-world experience of distress with her current living arrangements and family tensions. The second effect is of offering compensation or even apology for any disruptions these personalized expressions may have caused the ordered flow and tone of the psychiatric storyline.

Thus, the nurse-speaker's continuing response *"I understand, otherwise there isn't anything troubling you"* (lines 65-66) is as much an expression of her understanding of the universal human need for harmony as an acceptance of the client-speaker's apology for the potential disruption caused by these personalized expressions to the harmony of the unfolding psychiatric storyline. The client-speaker's repetition of the word *"otherwise, no"* (in line 67) has the effect of closing the cycle and further enclosing the social meaning of these life-world expressions within the 'to be expected' psychiatric surveillance storyline.

4.5.2.1.1.1 Positioning practices highlighted

In this persuading/deferring social action, the nurse-speaker is deliberately and actively positioning herself as arbiter of the moral order with the authority to simultaneously elicit particular descriptions from the client-speaker and to judge these against normative criteria. In so positioning, the client-speaker is forced to assume the polar position of deferring, passive client.

4.5.2.1.2 The social action of persuading/deferring doubts about medication in the direction of the to be expected storyline

> *"Ja::a, (.) but it's helping you [medication]?"*(Transcript 2 Appendix B line 24.)

This excerpt (23) illustrates how herding-hectoring is deployed around the key tool of clinic-based treatment: medication. This excerpts show how the client-speaker's opinions of his medication are expressed in the grammars of self-authorisation and how these authorizations are taken-up in the nurse-speaker's utterances as instances of resistance to the to-be-expected psychiatric storyline, decontaminated with varying degrees of force and then re-constituted as normative

markers of the efficacy of medication.

In this first excerpt (23) below the sequence opens in line 5 with the nurse asking the client if she is *"still taking"* her medication: this utterance carries with it the suggestion of non-compliance or at least, a query about medication compliance. This has the effect of calling the client to provide a clear account of both the frequency and specific times at which she takes it, thus positioning the client as competent with matters medication (lines 7-8). In this utterance, the client-speaker uses the language of the diagnostic-psychiatric paradigm to authorize her description of her medication-taking *"three times a day"*. That the nurse-speaker goes on to inquire about the *side effects* of the medication (lines 9-10) suggests that this account is sufficient to evaluate the client-speakers compliance with medication.

Excerpt 23 Persuading/deferring (Transcript 2 Appendix B lines 5-28)

5	2.1	PRaQ	Nurse: ((CIS))	Mmm (.) so:: concerning your ***medication***, are
6				you still taking your medication?
7		A	Client:	Yes, I'm taking it three times a day. Urr:: in
8				the morning, at lunch and at supper.
9	2.2	PReq	Nurse: ((OIS))	And the:n (.) how are the side-effects of the
10				medication?
11		A	Client:	(.2) It's hel:ping but er:: (.) you see I've (.)
12				they're giving me a different type of medication
13				here. I used to go (Street) clinic <u>first</u>. So (.)
14				they tell me like six months I get the tablets
15				and after six months I don't get the tablets. So
16				they give me something else in return. So that
17				is why I came here.
18	2.3	PRaeq	Nurse: ((CIS))	So::o (.) what were you getting in the (.) in the
19				clinic you were attending?
20		A	Client:	I was taking the other white er:: tablets, the
21				White tablets (Nurse: Mm::) but now they are
22				giving me the other one (.) the orange (Nurse:
23				Mmm::) pill.
24	2.4	PReq	Nurse: ((CIS))	<u>Ja</u>::: (.) but it's <u>helping</u> you?
25		A	Client:	(.2) J::a, I guess so ((laughs softly))
26				
27	3.1	PRaQ	Nurse: ((CIS))	Okay ((Laughs softly))::: (.) so:: (.) is there
28				anything that is ***troubling you***?

Following on from the nurse-speaker's elaboration question in lines 9 and 10 *"and then how are the side-effects of the medication"*, the client-speaker draws upon the helping effects of her medication to introduce a description of her doubt about whether the medication she is presently taking is the right type of medication because it is different from what she was getting at a previous clinic (lines 11-17). The social meaning being developed in this utterance is of misgiving about the category of psychiatric medication she is taking and not necessarily about its efficacy. The client-speaker draws upon both the grammars of self-ascription and her personal and previous experience of medication to authorize and to express doubt. The nurse-speaker's subsequent utterance *"Ja:: (.)"* in line 24 – a prolonged, emphasis on the agreement followed by hesitancy marker - indicates orientation albeit ambivalent, to this social meaning of doubt and signals the potential for a herding activity.

The nurse-speaker's continuing utterance *"but its helping you"* (line 24) initiates the activity of herding. This utterance has the effect of resisting the unfolding of these client-authored misgivings and of quite forcibly re-constituting them as marginal and beside the point, given the overall value of this medication in "helping".

The term "helping" is used as a resource by both speakers to manifest different understandings of medication in this conversational exchange cycle. Whereas it was first raised by the client-speaker as a precursor to an expression of doubt about the correctness of the category of medication (line 11-12), it is used by the nurse-speaker in this concluding medication elaboration sequence (line 24) as a precursor to compelling certainty – the certainty of the efficacy of medication and the authority of the nurse to proclaim this kind of certainty. The compelling effect of the nurse-speaker's utterance is taken up in the client-speaker's subsequent speech acts (in line 25: speech hesitation marker (.2) followed by a prolonged agreement sound *"J::a"*, the use of the word *"guess"* with its speculative overtone and the soft laugh) and manifest as an action of surrender, an admission of defeat.

The nurse-speaker's post-response (line 27-28) *"okay"* followed by a soft laugh

and a shift in topic to *"is there anything that is troubling you?"* suggest that this surrendering action has been accepted. The client-speaker's original act of self-positioning has been forcefully overturned through the nurse-speaker's deliberate positioning of herself as authority with respect to matters psychiatric and medication. The shift in topic *"is there anything troubling you"* effectively reframes the client-speaker's previous self-authorized misgivings as misplaced and inconsequential: as not having achieved the status of `problem' as defined by the psychiatric moral order of speaking within which the conversation is located. These utterances and particularly the soft laughs of both speakers suggest that some measure of consensus about what constitutes a legitimate concern about medication has been reached: a query about medication is visible as a problem only in the absence of the helping effects of medication. In the presence of these effects, concerns are marginalised as beside the point, as 'otherwise' to what is required for the manifestation of a problem.

I would suggest that in this excerpt the conclusion of this persuasion/deferring social meaning signals the successful accomplishment of the discursive activity of herding and that it is these joint, soft moderating laughs which mark this as a herding rather than a hectoring sequence. These utterances and particularly the soft laughs of both speakers (in lines 25 and 27) have the four-fold effect of moderating the coercive/surrendering force of the sequence, of signifying the accomplishment of the topic, of re-inscribing the meaning-making authority of the psychiatric agenda and specifically, the preeminence of medication, and of reinstituting interactional harmony.

4.5.2.1.2.1 Positioning practices highlighted

Within this persuading/deferring social action, the nurse-speaker is positioned as the delegated authority of the psychiatric moral order with rights to

compel a particular kind of meaning - self-authorized concerns about medication in the presence of its helping effects are inconsequential to the mandate of diagnostic-psychiatry - to be made known in dialogue and to use the psychiatric agenda to herd the conversation in the direction of this meaning. The client is thus positioned as morally bound within this order to defer his/her rights to self-authorized meaning making and to speak from the institutionally authorized position of obliging and enduring psychiatric patient.

I would further argue that while both speakers are differentially positioned in this social action with respect to the kind and degree of authority they may draw from the psychiatric moral order to inform the meaning-making process, both are subjected to the objectifying gaze of the psychiatric agenda. In this persuading /deferring sequence, both are required to surrender their rights to their respective speaking voices of person-centered nursing and self-authorizing client. Thus, the effect of herding is to position both speakers as instruments of the institutional order but with different and circumscribed rights to speak within the order. To this extent, both speakers are being forced to position themselves in relation to each other and more significantly, in relation to the higher authority of the psychiatric agenda (see section 3.4.3.3.2 for a fuller account of forced self positioning). Their joint soft laugh at the conclusion of this sequence suggests that the consensus meaning about what constitutes a problem with medication is a welcome reprieve for both speakers from the coercive effect of forced self-positioning.

4.5.2.1.3 The social action of persuading/deferring expressions of distress as inconsequential to the to be expected psychiatric storyline

Well you see someone put a tokolosk [curse] in my this thing..."/"So last month nothing happened then you took your tablets and you were fine last month?"

(Transcript 5 Appendix E, conversational cycles 2.1 (introductory sequence) and 2.14

(closing sequences.)

Client-talk in this text (transcript 5) differs from the other transcripts in that the client-speaker speaks very quickly with sentences and ideas running together. The text is peppered with self-authorized descriptions of "*talking too much*" of "*having nerves*" and of the relationship between talking and increased nervousness (cycle 5.7, lines 240-250) "*I got that nerves now, you see (.) I'm talking to you now (.5) if I talk too much, sister than I get nervous (.) see I'm getting nervous now [[lines 246-248 omitted]] ((starts to cry)) I'll stay quiet right=*".

This is a long herding action of 14 exchanges and can be found in Transcript 5, Appendix E, conversational sequence 2, lines 51-145. This sequence (lines 51-145) illustrates how even in the presence of self-authorized stories of life-world suffering and emotional distress, the social action of persuading/surrendering in the direction of the helping effects of medication, is manifest. The effect of this social action is illustrated in the opening and closing herding excerpts (24 and 25) from this conversational sequence.

In this cycle (2.1-21.4) the client-speaker holds the conversational floor with descriptions and explanations of his illness "*you know what happened (4 sec) uh: (.) this tokolosh somebody put ((it)) (Nurse: What's tokolosh?) "that thing (.) you know (.) he talks to me inside (Nurse: Mm) he talks to me inside, Ja. The first time I didn't know this (.) he talking to me and=*" (lines 54-58); of how the tokolosh controlled him and the things it made him do (lines 73-84); of how he managed to get rid of it using salt water treatments (lines 62-73); of how the "*doctor gave me some tablets too. He reckons to try and put it right (.) but now see (.) the sleeping tablets he gave me (.) I'm sleeping nice (.) and urr now I'm having peaceful*" (lines 85-88); of how a persistent ringing sound in his ears obstructs his hearing (lines 92-96) "*so I cant get your words in my ears*" (lines 138-141); of how he has got used to this ringing over time (lines 115-118); and of how his repeated requests for clarification sometimes makes other people angry (lines 129-

135).

The nurse-speaker's utterances are concise and on the whole, closed-ended information seeking questions about whether he hears voices (2.4, line 89); whether the ringing sound is active during the interview (2.6, line 97); whether it continues in the presence of medication (2.8, line 101); whether he covers his ears to block the sound (2.9, line 105-108); and whether the ringing upsets him (2.12, line 113-114).

The nurse-speaker's closed-ended information-seeking utterance in the opening sequence (Excerpt 24 over the page) calls for a yes/no response as to whether he took his tablets last month and was *"fine"* in himself and with his tablets. Herding is initiated in this speech act because it compels a circumscribed reply. Although this nurse-request for a circumscribed answer is not taken up in the client-speaker's subsequent descriptions of his past illness experience, these descriptions are taken up by the nurse-speaker in the closing sequence (Excerpt 25) **as if the required answer was given** (my emphasis): nothing that happened in the past has any bearing on the assessment of whether he is presently fine or not fine with medication (lines 142-145). This `as if it were like this' meaning is taken up in the client-speaker's successive agreement utterance *"Ja:: the medication is okay"* (line 145). The elongated sound on the "Ja::" followed by a hesitancy marker, gives this agreement a deferring or surrendering effect.

This jointly accomplished compelling /deferring speech action has the effect of bypassing the client-speaker's early illness-experience descriptions as inconsequential to the kind of meaning being generated in this sequence situated within the moral order of the clinic. Diagnostic-psychiatry draws on events and experiences in the person's immediate past to generate explicit descriptions of functional capacity that are used as normative markers of functional improvement or decline. Past experiences are only useful in as much as they contribute to an understanding of the vulnerability factors in the psychiatric history of the person and to establishing a time frame for the onset of the illness for the purposes of psychiatric

diagnosis.

Excerpt 24: Opening persuasion/surrender (Transcript 5 Appendix E lines 51-64)

51	2.1	PRaeq	Nurse: ((CIS))	So: last month nothing happened then, *you took your*
52				*tablets* and (.) you were fine last month ((the
53				medications () fine))?
54	2.2	A	Client:	You see: (.) what happened (4sec) uh: (.) this
55				(tokolosh) somebody put ((it)) (Nurse: What's
56				tokolosh?) that thing (.)you know (.) he talks to me
57				inside (Nurse:Mm) he talks tome inside, ja. The first
58				time I (.) I (.) I didn't know this (.) he's talking to me
59				and=[
60	2.3	PReq	Nurse: ((CIS))	]Who is this:: (.) (Client: uh?) Is this a person
61				talking to you?
62		A	Client:	No (.) you see what happened uh:: somebody
63				told me (.)that I must take Uh salt water (.) (Nurse:Mm)
64				in a cup of uh:: (.) ((palizer)) (.) right? (Nurse:Mm) (.)

Excerpt 25: Closing persuasion/surrender (Transcript 5 Appendix E lines 136-145)

136	2.13	PReq	Nurse: ((CF))	So you hear two things together (Client: Ja, ja) and
137				it's hard for you?=
138		A	Client:	=Ja. ja (.) like sometimes ask me a question and I say
139				"What you say?"(.5) cause you know why it's the
140				ringing obstructing it(.5) so I can't get your:: words in
141				my ears.
142	2.14	PRaQ	Nurse: ((CIS))	Oh. okay Mr (X) (.) so that's just what has happened
143				last month (.) and so (.) the medications they are (.)
144				okay?
145		A	Client:	Ja:: the medication is okay.

4.5.2.1.3.1 Positioning practices highlighted

Within this persuading/deferring social action, the nurse-speaker is once again positioned as the delegated authority of the psychiatric moral order with rights to compel a particular kind of meaning - past life world experiences are invisible or inconsequential within the context of the present helping effects of medication - to be

made known in dialogue and to use the psychiatric agenda to herd the conversation in the direction of this meaning.

The client is thus forcefully positioned as morally-bound within this order to surrender his rights to self-authorized expressions of his past experience and to account for himself from an externally imposed, circumscribed frame of reference.

4.5.2.2 Hectoring: Social action and positioning practices illuminated

4.5.2.2.1 The social action of compelling/surrendering well-being as a normative effect of medication

"I will assume the medication is helping you then?"/ "Oh:: Ok: J:aa"

I have taken the phrase *"I will assume the medication is helping you then?"* from transcript 6 Appendix F lines 41-43 to title this section because it captures how hectoring is deployed around medication across almost all of these texts. The word "assume" may be alternately understood to mean "taken for granted" and to this extent, fits nicely with the to-be-expected storyline. Further, the tonal emphasis in the use of this word increases the decontaminating effect of the nurse-speaker's normalising utterance.

In the following excerpt, the client-speaker uses the language of proof and the continuity of his personal biography in the grammars of self-ascription and self-evaluation to deliberately position himself as agent and to authorize a firm account of his personal identity as constant within and across present and future time and space and in the absence of medication: *"I believe I am a stable person and I should be taken off ((laughs))"* (lines 20-21).

Excerpt 26: Compelling/Surrendering (Transcript 6 Appendix F lines 10-46)

10				
11	2.1	PRaQ	Nurse: ((CIS))	(2sec) Mm:: Okay you get tired (.) ***do you come here every month (1sec) for your medication***?=
12				
13		A	Client:	=Yes.
14	2.2	PReq	Nurse: ((CIS))	I see you um: you are only on tablets?
15		A	Client:	And injections=
16	2.3	PRaeq	Nurse ((OIS))	=And injections (.) how is it treating you?
17		A	Client:	Um:: ((coughs)) To (.) to (.) uh::: to to to tell you the truth(.) um (2sec) I haven't noticed any
18				
19				difference (.) you know (.) As a:: (.) as a (.)
20				matter of fact uh::: I believe I am a stable
21				person (.5) and I should be taken off ((laughs))
22	2.4	PRaeq	Nurse: ((CIS))	Ja:::: (.5) so you're okay with this medication?=
23		A	Client:	=Ja=
24	2.5	PReq	Nurse: ((CIS))	=Would you say that it is helping you? =
25		A	Client:	=I suppose so, ja=
26	2.6	PReq	Nurse: ((CIS))	=((laughs)) You suppose?
27		A	Client:	(.)Ja=
28	2.7	PReq	Nurse: ((OIS))	=Do you know what is uh:: what (.) what you
29		are		
30				Taking this medication for?=
31		A	Client:	=Ja (.) yes=
32	2.8	PReq	Nurse: ((OIS))	=Can you tell me about it?
33		A	Client:	Well uh:: for schizophrenia [Nurse: Okay] and
34				for uh::(.) uh:: moods, Uh uh you know, mood
35				changes.
36	2.9	PReq	Nurse: ((OIS))	When was the last time you had uh (.) these
37				Mood changes?
38		A	Client:	(3sec) uh:: no (.5) a lo:ng time ago now [Nurse:
39				Long time?] cause I've been stable ((laughs
40				softly)).
41	2.10	PRaeq	Nurse: ((CIS))	So I will assume that this medication helps
42				[Client:Ja] O:h, okay. Does it? =
43			A Client:	=Ja=
44				
45	3.1	PRaeq	Nurse: ((OIS))	=(.) Uh:: HOW is your (.) your ***sleeping or (.) your eating***?
46				

I would suggest that the meaning being developed here is of client-authorised understandings of what constitutes psychiatric wellbeing and of this understanding as being mediated by factors other than medication, such as present and future biographical factors. This client-authorised meaning stands in contrast to this moral

context's perspective of wellbeing as a normative marker of psychiatric wellness and as the outcome of medication and as continually dependent upon medication for this outcome.

However, the client-speaker's *((laugh))* (line 21) at the conclusion of this utterance undermines the potency and veracity of this self-authorized positioning and in so doing, introduces the potential for negotiation about which version of meaning is manifest. This potential for negotiation is immediately taken up and attended to in the nurse-speaker's subsequent agreement utterance *"Ja::: (.5) so you are okay with this medication?=* (line 22). The elongated agreement sound *"Ja:::: "* followed by the hesitancy marker (.) has the effect of acknowledging the client-speaker's right to self-authorisation but of rejecting the client-authorized meaning about biographical wellness and the role of biography and medication in sustaining wellness. This personal meaning is immediately overturned in the nurse-speaker's continuing utterance and reframed as a marker of satisfaction with medication: *" so you are okay with this medication?="* (line 22).

The client-speaker's subsequent monosyllabic agreement with this understanding *"Ja"* (line 23) is taken up by the nurse-speaker in a singularly forceful and circumscribed utterance: *Would you say that it is helping you?"* (line 24). This close-ended, information-seeking question compels a yes/no response from the client-speaker. Although the client speaker's answer *"I suppose so, ja="* is an agreement response (line 25), it is tentative and the agreement effect *(ja)* is tempered with misgiving (*I suppose so*).

The effect of nurse-speaker's subsequent laugh and repetition of the words *"suppose so"* with a questioning emphasis (line 26) is to introduce an element of surprise at this non-yielding or non-deferring agreement response to the compelling force of the close-ended question. The social meaning being developed here is of dispute over which meaning (client-authorized or context-authorized) about the relationship of wellness to medication and to biography, will manifest. This struggle

for interpersonal meaning is manifest in this compelling/resisting social action and signals the beginning of the discursive activity of hectoring.

This hectoring effect is intensified in the nurse-speaker's successive elaboration question in sequence 2.7, line 28-31: *"do you know uh (.) what you are taking the medication for?"*. In this utterance, the nurse-speaker draws directly from the expert body of knowledge of diagnostic-psychiatry to authorize the request for information about the diagnosis for which the medication was prescribed. The effect of drawing authorisation from this source is to challenge the client-speaker's right to self-authorized evaluations of what it is to be stable and of the relationship between stability, biographical life-events and the efficacy of medication.

The client-speaker turns to this same body of diagnostic-psychiatric knowledge to authorise his naming of his illness: *"Schizophrenia and mood changes"* (line 33-35). However, the speech hesitations and non-vocal sounds preceding *"Well uh:: (.)"* and following *"uh:: (.) uh:: moods uh uh"* the diagnosis of Schizophrenia and mood changes have the effect of deferring authority for meaning-making to the psychiatric context and signal the beginning of a shift in social action from compelling/resisting to compelling/deferring. The nurse-speaker's subsequent elaboration question draws further from this body of knowledge to establish the basis for developing an argument for a temporal relationship between the symptom mood changes and the efficacy of medication (lines 36-37).

The compelling effect of this persuasive line of argument is dialogically linked to the client-speaker's effort to resist it and ultimately, to its surrender (lines 38-40). The three second speech pause and the non-vocal sounds *"(3 sec) uh:: no (.5)"*; the description of the mood changes having occurred a long time ago together with the tonal emphasis on the long; the reintroduction of the word *"stable"* to describe himself; and the soft laugh give the utterance a suplicatory and surrendering meaning. This surrendering effect is taken up in the nurse-speaker's penultimate and ultimate utterances in lines 41 *"So I will assume this medication helps;* line 42 *Does*

it?" to which the client replies with a monosyllabic but unequivocal *"Ja"*. This surrender together with the introduction of a new topic *"sleeping and eating"*, signals the completion of the compelling/surrendering social action in this conversational sequence.

Diagnostic-psychiatry's perspective of wellbeing as a normative marker of psychiatric wellness and as the outcome of medication, rather than the client-authorised understanding of wellness as being mediated by present and future biographical circumstances, prevails. Whereas everyday life experiences may be subsumed within the ontology of diagnostic-psychiatry, they are to be used to illustrate points of functional improvement/impairment rather than as experiences to be explored for their own worth and meaning (Horwitz, 2002).

4.5.2.2.1.1 Positioning practices highlighted

What is significant with respect to positioning in this social action is that although a number of different positioning practices might be deployed-taken within the unfolding action/storyline, the manifest meaning is determined by which of the positions is jointly sustained in dialogue. Thus while the client-speaker at first deliberately positioned himself as agent in lines 17-21, this position was overturned in the nurse-speaker's subsequent positioning of herself as agent for the efficacy of medication and the client as passive, accounting subject.

Although the client-speaker might have discursively resisted this passive account of himself, the extent to which these positions were forcibly sustained in the on-going dialogue is evident in the degree of surrender associated with the monosyllabic client-response *"ja"* to the nurse-speaker's final call for the efficacy of his medication.

4.5.2.2.2 The social action of compelling/surrendering expressions of agency as effects of the therapeutic properties of the psychiatric moral order of speaking

"=so would you say talking about it doesn't help?"/No, well, sometimes, maybe, no" (Transcript 7, appendix G lines 66-68)

In this conversational cycle (3.1-3.4, lines 62-110), the nurse-speaker draws from the discourse of person-centered psychiatric nursing and her own biography to authorize and to maintain the compelling/surrendering effects of hectoring in the direction of the to-be-expected storyline. This is a long sequence and it has not been inserted here for ease of reading. It can be found in transcript 7, Appendix G, lines 62-110.

The preceding conversation opens with an inquiry from the nurse about whether the client is still feeling anxious and depressed (lines 18-19). The client affirms feeling depressed and in response to the nurse's elaboration question of what brought it about, gives a description of the events of the past year (lines 22-33). These events include the death of her husband from renal failure, the divorce of her daughter after a six-month marriage and the deterioration in her son's performance at school during this period. The nurse-speaker's utterance in line 43 (cycle 2.6): *"so how have you been coping?"* is evocative of the person-centered approach of psychiatric nursing in that it at least attends to the nuance of a life-world problem. The client-speaker offers a succinct account of her coping: *"I was terrible but I have my days. Sometimes I am very depressed, sometimes I am okay"* (line 44-46). She further describes how her son's performance at school has also improved and that *"he's come up to the A-level again."* (lines 53-56).

This client-centered account of personal mastery is formulated in the nurse-speaker's subsequent response as if coping and change for the better was the

outcome of the helping effects of the clinic, rather than of personal mastery: "*Okay: so you're saying that since you've, err, come here, you have seen that, a change (.) u:m the clinic has actually helped you?*"(cycle 2.7, lines 57-59). In this utterance, the linking of change for the better with the helping property of the clinic has the effect of by-passing the client-centered meanings made manifest in response to the original coping query. The client-speaker's subsequent agreement response to the helping effects of the clinic in line 60 "*Yes, it has helped me, yes*" suggests some consensus about helping and the clinic has been jointly established but how this helping effect is respectively understood is unclear for the moment.

The nurse-speaker's understanding of what constitutes the helping effect is manifest in the successive utterance (lines 59-63) where the clinic and the benefits of speaking about problems are dialogically linked. The client-speaker's ensuing ambivalence and then disagreement with the idea of talking as the helping effect of the clinic, suggests that something other than talking is more helpful: "*Hmm, not really. But, sometimes it does help. Not really. Not to such a great extent=*" (lines 64-65).

Divergent accounts of what constitute helping in the context of the clinic, are thus emerging. Divergence introduces the potential for negotiation and struggle for meaning and I would argue that it is at this point in the dialogue that the discursive activity of hectoring is initiated in the nurse-speakers' quickly inserted post-response elaboration question in lines 66-67: "*=So would you say talking about it doesn't help?*". The compelling effect of this nurse-speaker's utterance is visible in the way in which the client-speaker's ambivalence about the helping effects of talking is reformulated as a client-expression of unconditional resistance to this same idea. The compelling effect of this re-formulation is visible in the client-speaker's subsequent yielding response to how the helping effects of talking may be manifest in some situations and not in others: "*No, (so) you see what I appreciate, when I have an interview like this, I do still discuss it. But when I see the Doctor, there's no discussion. He doesn't really ask me anything or do (anything) (.) he just [*" (lines 68-72).

I would argue that the force of this compelling/yielding social action is subsequently off-set by both speakers in the direction of an absent third party -the doctor - rather than negotiated within the unfolding dialogue. This is probably the only example of third order positioning in these texts. In this sequence of conversation (3.2), talk with the nurse is being constituted as dialogue (*when I have an interview like this, I do still discuss it*). Talk with the doctor on the other hand, is being jointly constituted first, as a monologue about medication and satisfaction with medication and secondly, as uncaring and as unfair (lines 68-82):

Excerpt 27: The Doctor and 3rd order positioning (Transcript 7 Appendix G lines 68-82)

68		A	Client:	=No. (so) you see what I appreciate, when I
69				have an interview like this. Ido still discuss it.
70				But when I see the doctor, there's no
71				discussion. He doesn't really ask me anything,
72				or do (anything) (.) he just[
73	3.3	PReq	Nurse: ((CF))	] you feel like he's just
74				(doing his job), he doesn't care about you?]
75		A	Client:	[Yes. He's
76				just, err, he just ask me, is the medicines
77				okay? Will you continue with the same one?[
78				Nurse: That's not fair] and that's it. That's it.
79				Nothing else.
80	3.4	PRaID	Nurse: ((ID))	Okay. You must always realise that we are
81				here to help you. If you can't speak to us, um,
82				it's like, you're not going to be of benefit to

The effect of this offsetting in the direction of the absent doctor is to reduce discord in this conversation about how the helping effects of the nursing dimension of the clinic are to be understood. The placing of discord outside of the conversation enables the speakers-in-conversation to continue as if they are in agreement about the helping effect of the clinic. Whereas the conversation with the absent doctor is constituted as uncaring because of the absence of discussion and its focus on medication, this nurse-client interview is constituted as a caring dialogue. Thus, both helping effects of the clinic – talking (nurse) and medication (doctor) – have been reconciled and accommodated in this conversation.

This newly aligned dialogue with its reconciled understandings about what constitutes helping at this clinic, and particularly, the caring effects of nurse-talking, is dialogically linked to the nurse-speaker's subsequent lengthy monologue about life-world problems and strategies for coping. This compelling monologue runs from lines 80-109 (cycle 3.4, Appendix G) and might be conceptualised as a diatribe of caring. The coercive effect of this monologue lies not only in its length. It lies in the way in which the nurse-speaker draws on her own personal biography rather than that of the client, to authorize the monologue such as: "*from my personal experience, speaking about it, I promise you, it like, lifts up a burden, and at the end of the day, you feel so much better and at ease*" (lines 83-86); *Like we::e all are here like, I am, I am, as I sit across you, I (.) you may think, like, I have no problems in my life, I am fine, I am fine. But each one has their problems of their own*" (lines 96-98).

It lies also in the way in which these traumatic events and previous client-authorized expressions of coping with these events are minimized as "*And as much as we have our problems and our ups and downs*" (lines 86-88 and repeated "*we all have our ups and downs in life*" in lines 91-92) and re-constituted as to-be-expected occurrences of the unfairness of life, *"Life is not fair."* (line 92). It lies in the way in which the nurse-speaker's frequent uses of the phrases "*You know?" what I mean?*" and "*You know what I am saying*" to emphasize a point and coerce agreement, for example: "*And as much as we have our problems and our ups and downs, speaking about it, praying, you know? It really helps. Together with medication, you know? (Client: Yes)* (lines 86-89); "*And other alternatives like cook, clean, talk to you kids, you know? Like, if you are feeling the loss of your husband, the kids are there to make up for it. You know what I am saying? (Client: Yes.)*" (lines 104-108).

This coercive effect lies further in the way in which awful life events re-constituted as normative to which *"each one"* is subject and which each one must "*just learn to deal with in a different way, that's what we need to do*" (line 98-100) and "*must just find ways, you know, in which we can overcome them* (101-102)" such as praying,

medication and *"other alternatives like cook, clean, talk to your kids, you know? And always think that you have them with you. They have so much love="* (lines 104-109).

The social meaning being developed here and around which the compelling/surrendering action of hectoring is manifest is that while client-authorized expressions of personal biography (feeling and content) are manifest, their sustained manifestation is dialogically linked to the extent to which they are a resource for the normalising of those expressions in the direction of the to-be-expected storyline. These normalized expressions of problems and coping are then taken as a marker of a change for the better, as a marker of a caring and finally, as the accomplishment of the topic: *"But, you're eating well, you're sleeping well?"*. Client: *yes"* (lines 112-114).

4.5.2.2.3 The social action of compelling/surrendering life-world distress in the direction of instrumental problem-solving

> *"Well, I suggest you go to sleep later then, ja:: maybe it might help you (.) Ja."*
> (Transcript 2 Appendix B lines 95-97.)

In this cycle, the nurse-speaker draws from the discourse of problem solving to authorize and to maintain the compelling/surrendering effects of hectoring in the direction of the to-be-expected storyline. This too is a long excerpt and can be found in Transcript 2 Appendix 2 cycle 4.1-4.12, lines 69-114.

The excerpt opens with the nurse-speaker asking after the client's sleeping and eating patterns. The client-speaker responds *"I generally don't sleep well"* (line 71). The nurse-speaker asks, in the form of an open-ended question, for a description of this experience (line 72). The client offers a partial description, which suggests that her not sleeping well is in spite of the sleeping tablets (lines 73-74). Conversational cycle 4.3 explores the duration of this problem and cycles 4.4 and 4.5 explore the time

of sleeping and of waking respectively. The client reports the onset as a "*couple of months*" (line 76), as going to bed at 6:00 pm (line 78) and as being awake half the night in spite of the tablets (lines 81-86).

The effect of the nurse-speaker's subsequent solution-oriented question in cycle 4.6 lines 87-91: "*so:: do you wanna to change maybe you should change your sleeping habits then maybe sleep at abo::ut nine o'clock?*" is to suggest that the client-speaker's problem of being "*awake half the night*" has been identified as sleeping too early (6:00 pm) and therefore waking too early. That sleeping later is neither the problem nor the solution is evident in the 3-second pause preceding the client-speakers answer "*I can't sleep late*" and in their joint soft laughs following this utterance (lines 90-92). The client-speaker's pause and the joint soft laughs have the effect of moderating the divergence of opinions emerging in this cycle.

Although the nurse-speaker's post-response elaboration question "*Okay,* ((soft laugh)) *hhh so:: (.5) what do you think you will do then*" (line 92-93) may be interpreted as an open-ended question facilitating the client's exploration of her own coping resources, this request initiates the hectoring effect of the compelling/surrendering social meaning being developed. This compelling effect is visible in the extent to which the client-speaker's (2 sec) conversational pause, the soft laugh, together with the tonal emphasis on *you* and *me* and the imperative effect of the word "tell", gives this utterance a challenging effect: it is you the expert nurse who should be telling me the helpless patient what to do about this problem. "*(2 sec) ((Laughing softly)) You should tell me.*" (line 94).

This discursive challenge to the authority of the practice of problem solving is taken up in all of the nurse-speaker's subsequent responses – exchange sequences 4.8, 4.9, 4.11 and 4.12. Whereas the nurse-speaker's first suggestion of changing the sleeping pattern to manage the sleeping problem is developed around the authority and agency of the client in this matter "*so:: do you wanna to change maybe you should change your sleeping habits then maybe sleep at abo::ut nine o'clock?*"(line 87-89) the

utterances subsequent to the discursive challenge "*You should tell me.*", are developed around the authority of the nurse and of the bio-medical model.

For example, excerpt 28 below illustrates how the original solution of going to bed earlier is authoritatively and repetitively re-inscribed as a formal problem management recommendation that is given in response to both the client-speaker's 'request' for advice (line 95-96 below) and the client-speaker's on-going, personalized explanations for why she is having trouble sleeping (in lines 98-100 and 103 below). Further, the nurse-speaker draws upon the authority of the biological model of illness to account for the client-speaker's pains (101-102) and thus, recommend a course of action.

Excerpt 28: Compelling/Surrendering (Transcript 2 Appendix B lines 92-118)

92	4.7	PReq	Nurse: ((OSo))	Okay (soft laugh)) hhh so:: (.5) what do you
93				suggest you will do then?
94		A	Client:	(2sec) ((Laughing softly)) You should tell me.
95	4.8	PRaID	Nurse: ((ID))	((Laughs softly)) Well I suggest that you (.) go
96				to sleep later then, ja::, maybe (Client: Mmm:)
97				it might help you(.) ja.
98		A	Client:	Sometimes when I go to sleep to:: (.) I can't
99				sleep because of these pains that I've been
100				getting you (Nurse: Mmm) know.
101	4.9	PRID	Nurse: ((ID))	(2sec) Then I suggest that maybe you (.)
102				should go to see a doctor then=
103		A	Client:	=I'm under a lot of stress too (.) you see.
104	4.10	PReq	Nurse: ((CIS))	(2sec) Then what (.) Okay (.) What (.) about
105				your boyfriend?
106		A	Client:	He gives me too much problems. too much. He
107				((boyfriend)) worries me a lot.
108	4.11	PraID	Nurse: ((ID)	(5sec) Ja, I see (4sec) but I suggest that you go
109				(.) to (.)bed later than (.5) later than six.
110				Maybe at nine (.) or eight (.5) then maybe (.) it
111				might help you=
112		A	Client:	=If I go to sleep early I get up early.
113	4.12	PRaID	Nurse: ((ID))	Oka:::y (2sec) Oh (2sec) So then (.5) try that=
114		A	Client:	=Try and sleep later?
115	5.1	PRaID	Nurse: ((ID))	Ja (.) I think it might help you (3sec). Anyway,
116				thanks again. ***See you next time.*** Then I will
117				write your return date it is on the 23rd of (tape
118				ends)

In these nurse-speaker responses, the grammars of self-ascription are

authoritatively and repeatedly linked with concrete recommendations for managing the problems of sleep and pains and it is this association of authority and recommendation that gives these responses an inexorably hectoring effect.

4.5.2.2.3.1 Positioning practices highlighted

It is my argument that there is a difference between how hectoring is accomplished in this sequence and how it is accomplished in the previous exemplars. In these exemplars, the compelling/surrendering effect of hectoring is visible as a jointly manifest phenomenon with the nurse positioned as compelling and the client as first resisting and then surrendering to the normalising effects of hectoring. I would argue that there are no textual indications of surrender in the client-speaker's responses and yet this sequence meets the criterion for hectoring. I would suggest that this compelling/surrendering social action is manifest primarily in the nurse-speaker's utterances and that it is the nurse-speaker who, in dialogue with the moral order of speaking underlying the context within which this conversation is situated, has both compelled and surrendered to the normalising effects of this order. I would further argue that this psychiatric moral order compelling/nurse surrendering effect underscores the authority of moral orders of speaking in generating meaning in context. The challenge of course, would be to get the moral order of psychiatric nursing to call with equal authority.

4.6 The (in)visibility of heeding in these texts

To what extent is the discursive activity of heeding visible in these texts? I have already suggested that there is very little textual evidence for the activity of heeding in these texts. I would like now to show how, from a positioning theory perspective this is the case and with what effects for their going on together in

conditions of relationship.

The term 'heeding' was earlier used to describe the social effect of the conversational sequences wherein instances of client-agency are manifest and sustained as intelligible actions of self-authorisation in episodes of nurse-client interaction. From a positioning theory perspective, instances of client-agency are visible in talk in three overlapping ways and for talk to warrant the characterisation of heeding it must manifest, attend to, and sustain these ways of talking in the evolving conversation. These ways have been described in chapter 3 and are summarised here as being visible in talk: (a) in the drawing upon personal experience (ethics, thoughts, feelings, impressions, meanings, and beliefs), (b) in the drawing on biography (descriptions of life-world events, experiences and interactions), and (c) in the drawing on moral rights to speak in various moral contexts (Gergen, 1999; Hare and van Langenhove, 1999).

This constructionist understanding of heeding shares similarities with psychiatric nursing theory's understanding of the client-centred interpersonal process discussed also in chapter 3. Within the context of this understanding, client-centred talk is talk that simultaneously attends to and is responsive to: (a) the client's biographical and personal responses to actual or potential mental health/psychiatric problems; (b) the client's needs, beliefs, goals and expectations for mental health/psychiatric care and; (c) client-authorized expressions of self-determination, independence, and decisional choice in these health-related matters (Cumbie, Conley and Burman, 2004; Hagerty and Patusky, 2003; Forchuk and Reynolds, 2001; Peplau, 1952). Communications, and particularly, open-ended questioning in respect of these areas and empathic formulations, are regarded as the primary medium through which client-centered attending and responding in talk is deployed.

It is my understanding of positioning theory that while the activities of interpersonal attending and responding are necessary to manifest client-centered talk, this focus alone is insufficient to warrant the characterization of heeding. The

argument here is that for nurse-talk to merit the characterisation of heeding, it must attend to, respond to and **sustain** (my emphasis) these ways of expressing agency in the client-speakers talk within the evolving conversation. On the one hand, my giving emphasis to the activity of sustaining – of upholding and of carrying through - in the context of the modern psychiatric nursing understanding of the attending and responding dimensions of the interpersonal process, might seem finicky. While these are the defining characteristics of person-centered talk, the activity of sustaining is not adequately emphasized in this discourse. Therefore, it is my argument that it is this lack of emphasis on sustaining in client-centered talk that inadvertently marginalizes possibilities for heeding talk.

It is therefore my analysis that while there are fragments of the first criterial doing of heeding talk (attending and responding) within these conversational cycles, these cycles can not be said to be exemplars of heeding because the overall social effect of heeding – to attend, to respond and to sustain these ways of doing client-agency - has not been accomplished in these cycles.

There are instances of nurse talk in these texts that meet the first criterion of heeding, which is, of attending and responding in person-centered talk. These have been identified in the transcription process as open information seeking and feeling focussed questions, some of which may also have an explicit empathic effect in the use of feeling words. There are a number of instances of nurse talk that attend and respond to the mandate of psychiatric nursing, that is, to the client's biographical and personal responses to actual or potential mental health/psychiatric problems; to the client's needs, beliefs, goals and expectations for mental health/psychiatric care and to client-authorized expressions of self-determination, independence, and decisional choice in these health-related matters. However, these instances can not be said to be heeding because this talk is not sustained in the unfolding interaction. Two of these first criterion instances are illuminated below.

4.6.1 Instances of client-centered talk in the texts

Excerpt 29 below is taken from transcript 2, conversational cycle 3.4-3.8, lines 45-69. Parts of this cycle were used in section 4.4.2.2.1 to illuminate the discursive effects of herding along the normalising "*Otherwise (anyway), everything is okay/fine*" storyline. The topic for this nurse-initiated cycle is "*so, is there anything troubling you?*" and the "*trouble*" being discussed in this excerpt is troubles with the boyfriend.

Excerpt 29: Instance of client-centered talk (Transcript 2 Appendix B lines 45-69)

45	3.4	PReq	Nurse: ((OIS))	What problems (.) what problems does he give?
46		A	Client:	(.5) He's always (.) like (.) fighting and arguing
47				(.) and stuff like that.
48	3.5	PRaeq	Nurse: ((OF))	With you? And then (.) how does that make
49				you feel?
50		A	Client:	(4sec) I told him that if he, he wants to be
51				separated, he is welcome to do so because I'm
52				ay:: (.) I'm one person that (.hh) I can't stand
53				nonsense. (Nurse: Mm::hh) That is why I
54				suffer with my head [Nurse: What did he say?]
55				it's the tension=
56	3.6	PReq	Nurse: ((OIS))	=What did he say then?
57		A	Client:	Mm:: (.) he doesn't wanna say anything, he
58				doesn't want to leave me (Nurse: Mm::) (.2)
59				You s::ee I'm living with my aunty (Nurse: Ja)
60				I don't have a place (.) of my own.
61	3.7	PRaeq	Nurse: ((CIS))	Mmm:: (2 sec) So:: (3sec) Anyway. (.5) Is it
62				better now?
63		A	Client:	(3sec) Ja, .hhh ((laughs softly)) it is but I would
64				prefer a place of my own=
65	3.8	PRaQ	Nurse: ((CIS))	=Ja (2sec) I understand. So you say otherwise
66				there isn't anything that's troubling you?
67		A	Client:	Otherwise, no.
68				
69	4.1	Prq	Nurse: ((CIS))	Mm:: (.) So (.) are you are still ***sleeping well***

The nurse-speaker's use of an open-ended information seeking question "*What*" in cycle 3.4 (line 45) to explore the client-speaker's understanding of problems with her boyfriend is an example of client-centered talk: the nurse-speaker has attended and responded to one of the life-world issues raised in the client-speaker's previous talk.

The nurse-speaker's subsequent question in cycle 3.5 is another example of client-centered talk in that it facilitates client-speaker expressions of her personal and emotional responses to the problem. This facilitation is extended a little further is cycle 3.6 in the form of an open-ended information-seeking "*what*" question that calls the client-speaker to give a reporting of events "*what did the boyfriend do and say?*" from her personal biography. The client-speaker's provides a brief response to this question and then introduces the problem of not having a place of her own to stay (line 59-60).

Client-centered talk in this sequence is abruptly truncated in cycle 3.7 and 3.8. In these cycles, the nurse-speaker's utterances deliberately miss the "*I would like a place of my own to live*" expression in the client-speaker's talk, introduce the counter-idea of things being "*<u>better now</u>*" (line 61-62) and then simultaneously conclude this idea and this conversational topic with "*otherwise, there isn't anything troubling you?*" (line 65-66). This by-passing effectively subverts the activity of sustaining that was developing in this sequence. The kind of social meaning being developed here is that troubling circumstances are routine to the round of daily life and therefore, "otherwise" to the troubles (and potential troubles) with which the psychiatric agenda is explicitly concerned and introduced at this conclusion: " *Mm:: (.) So (.) are you still eating well and still sleeping well?*" (lines 69-70).

I would argue therefore, that while the nurse-client utterances in 3.4, 3.5 and 3.6 meet the first criterion for heeding, that is, of attending and responding to client-authorized expressions of agency, these expressions are not sustained sufficiently in the subsequent nurse talk for this sequence to warrant the characterization of heeding. I would further suggest that while these fragments of client-centred talk have the effect of calling forth person-centered utterances, they have the simultaneous effect of herding the social meaning being developed in the direction of the to-be-expected psychiatric storyline.

The argument here is that in the absence of the discursive activity of heeding,

occasional expressions of client-centered talk might work inadvertently to sustain the normalising effect of the to-be-expected psychiatric storyline within the unfolding dialogue and in so doing, the authority of the psychiatric moral order or speaking (Gardiner, 2000).

4.6.2 Another instance of client-centered talk

The same argument is applied in analyzing the following illustrative excerpt (excerpt 30 is presented over the page). In the absence of heeding, client-centered expressions of agency in talk situated in the psychiatric moral order of the clinic might be one of the discursive mechanisms through which the authority of the order is maintained. Although client-oriented talk is much more visible in this unfolding dialogue than the previous excerpt, the social outcome of this cycle is similar: troubling circumstances are routine to the round of daily life and "otherwise" to accomplishing the psychiatric agenda.

The speakers in the excerpt below (Excerpt 30, Transcript 1, Appendix A, lines14-38, cycle 3.1-3.4) speak jointly from evaluative and explanatory positions deployed around the client's biographical and personal responses to actual or potential problems: family relationships intertwined with economic support.

The nurse-speaker's open-ended utterances in 3.1, 3.2, 3.3 and 3.4 have an overall effect of attending and enabling client-centered talk. Client-authorized meanings are taken up in the nurse-speakers post response assessment elaboration questions and to this extent, meet the first criterion for heeding: *"Yes okay so you seem to be taking to be all the more with your family able to handle everything?"* (Lines 22-24); *"So you are saying it's not easy staying at home not working?"* (Lines 31-32); *"Mm I see so you are saying but that but otherwise your children they make it easier for you?"* (Lines 35-36). This excerpt is presented over the page.

However, I would argue that a normalising thread of 'all these experiences are to be expected and therefore non-problematic' within the context of the psychiatric moral order of speaking, is simultaneously being developed and has the effect of subverting the development of heeding in this interaction, in two related ways.

Excerpt 30: Another instance of client-centered talk (Transcript 1 Appendix A lines 14-37)

14	3.1	PRaQ	Nurse: ((OIS))	So (.) tell me about your ***relationship*** (.) I mean (.)
15				within the ***family*** (.) all of you (.) how do you:: (.)
16				live(.) with each other?
17		A	Client:	Oh: we get well (.) we get on very well.
18				Nurse:Okay.) I have good children. They look after
19				me. We get on nicely (Nurse: Okay, I see) sometimes (.)
20				you know how it is (.) families do
21				have a small argument but that's not worth a fight.
22	3.2	PRaeq	Nurse: ((CF))	Yes (.) okay (.) so you seem to be taking (.) to be (.)
23				all the more (.) with your family (.) able to handle
24				everything?
25		A	Client:	Ja:: much (.) much so (2sec) and the children will
26				Look after me. They (.) they (.) like my daughter
27				and my son that's working they (.) contribute
28				towards the house like groceries (Nurse:Okay,
29				okay) I'm not working at the moment.
30				Nurse:Okay) (.5) It's not so e::asy but its (.) okay.
31	3.3	PReq	Nurse: ((CF))	So you're saying it's not easy staying at home (.)
32				not working?=
33		A	Client:	=Ja especially when you don't work hey? and you
34				need money (Nurse: Mm::) you know?
35	3.4	PReq	Nurse: ((CF))	Mm:: I see (.) so you are saying but that (.) but
36				otherwise your children they make it easier for you?
37		A	Client:	Much (.5) very much so hey?

In the first instance, the nurse-speaker's repetition of the phrase *"so you [seem/are saying]"* in lines 22, 31, and 35 and linked with positive coping utterances such as *"but…with family…able to handle everything"* (lines 23-24); *"but otherwise…children …easy?"* (line 36), has the effect of attributing the social meaning of her subsequent normative coping evaluations to the client, thus positioning herself

as knowing observer of the subject of discussion, that is, the client (Gergen, 1999; Mills, 1997; Smart, 1985).

In the second place, these same phrases re-inscribe the client's personalized experiences as routine and normal to daily life and the idea that these descriptions are necessary to establish an aggregate estimation of the degree of client-functioning in the family relations domain of the psychiatric agenda. The introduction of the next topic "*Okay (.) Alright (.) how's your medication?*" (see transcript 1 Appendix A line 38) suggests the family relations item has been accomplished and that further forays into the life-world of the client are unnecessary for the doings of the psychiatric moral order of speaking.

4.6.3 Positioning practices highlighted

The relative absence of heeding dialogue suggests that this form of knowing and other potential forms have been marginalised within this moral order of speaking. In this respect, the very marginal position of heeding relative to the centrality of highlighting, herding and hectoring, is consistent with the reported experiences of these students. This is not to suggest that client-centered talk is absent. The analysis has shown that there are instances of client-centered talk but that these are not sustained sufficiently to warrant the characterization of a positioning theory account of heeding.

4.7 Summary and conclusion

The analysis has shown that from a social constructionist positioning perspective, the unfolding nurse-client dialogue in these texts operates in three potentially distinct ways with specific effects for their going on together in conditions

of relationship. These ways were identified as highlighting, herding and hectoring. I have shown that the end-point effect of these activities is to normalise the nurse-client talk within the direction of the to-be-expected psychiatric storyline of the psychiatric moral order of speaking. These ways of talking are contrary to the person-centered rhetoric of modern psychiatric nursing and are more aligned with the bio-medical format of talk in helping contexts (Latvala, Janhonen and Wahlberg, 1999; Silverman, 1997 and 2001; Mishler, 1997).

I have argued that highlighting is manifest in the jointly developed social action-positions of inquiring nurse and accounting client and that the relative interactional agreement about the kind of social meaning being generated here marks it as a first order highlighting discursive activity. I have shown that the kind of social meaning being generated in this activity is psychiatric in nature and that this meaning is consistent with the ontology of diagnostic psychiatry and the psychiatric clinic. In this activity, the nurse and client are highlighted or individualised within their respective speaking positions of inquiring judging nurse and passive accounting client within the diagnostic-psychiatry moral order of the clinic.

The analysis has further shown that the social action of herding and hectoring are initiated when there is dispute or the potential for dispute about the kind of meaning being generated in dialogue. I have shown that herding and hectoring are differentiated with respect to the degree of interactional force required to maintain these psychiatric-authorized positions/social meaning in the direction of the to-be-expected psychiatric storyline. Herding is largely accomplished through the social action of persuading/deferring with both speakers asymmetrically positioned with respect to their rights to speak in the moral order of the psychiatric clinic. Whereas the nurse-speakers are authorized to elicit particular descriptions from clients and to evaluate them, clients are authorized to offer non-evaluative psychiatric descriptions of their wellbeing over time.

Herding towards the to-be-expected psychiatric storyline is initiated in

response to client-authorized expressions of past and present life world distress and self-expressed doubts about medication. Nurse-speakers were shown to deliberately take up moral order authorized positions of psychiatric expert in their talk with the right to decide the topic of talk and how talk about the topic should unfold. In most cases, nurse-speakers drew upon the idea from diagnostic-psychiatry that all forms of human behaviour are potentially markers of functionality and/or impairment, rather than needs to be addressed, to inform their speaking. Thus, emerging client-authorized speaking positions in these instances were overturned through the creation of moral-order sanctioned quiescent speaking positions for clients.

Hectoring was shown to be accomplished through the social action of compelling/surrendering. This social action was generally initiated by the nurse-speakers in response to client-authorized expressions of resistance to the kind of meaning being generated in dialogue. Client-speaker expressions of social problems and expressions of doubt and disagreement over elements of the psychiatric agenda were inexorably compelled through the social action-positions of knowledgeable nurse and novice client, to surrender their life-world meanings to the to-be-expected storyline.

I have also argued that the few instances of client-centered talk in these texts do not, from a positioning theory perspective, warrant the characterization of heeding talk because they fail to sustain this focus in the unfolding dialogue. These instances might be conceptualised as empathic from a modern person-centered psychiatric nursing perspective and they might also be seen to initiate the psychiatric nursing mandate. However, I have shown that their overall effect in these texts is to marginalize this mandate through the way in which they are firstly, not sustained in talk and secondly, recruited into normalising service of the psychiatric mandate. Furthermore, notions of holism – most often described as the essence of nursing- are almost invisible in these sequences. The social and cultural context of illness, together with personal meanings and interpretations people ascribe to the experience of

illness are regarded as the territory for nursing's work (Olsen, 2001; Paton, 2005; Peternelj-Taylor, 2002). However, there is little evidence of work in this area in these sequences. This is not to suggest that the biographical voice of the client -speaker's are absent but rather, that it is the biological voice that is taken up more readily and sustained more easily in the nurse-speaker's utterances, thus bringing a biological and physical understanding to the interaction (Hyde et. al., 2005; Mishler, 1984; Young, 1999).

That these normalising nurse-client discursive activities are at work in these texts is hardly surprising. Positioning theory argues that interpersonal meanings constitute and are constituted in social practices circulating in specific institutional contexts and that these meanings bring intelligibility to institutional principles and practices. The visibility of the moral order of the psychiatric clinic and the relative invisibility of the person-centered rhetoric of psychiatric nursing in these texts has been illuminated. What is noteworthy is the extent to which the psychiatric moral order of speaking calls both speakers to account for the intelligibility of their actions from within this order. In this respect, both the nurse and the client are positioned by this order as its active instruments but with different and limited rights to speak and to act. While there are fragments of person-centered discourse in the texts, this way of speaking is marginalised within these texts. The irony here is that the psychiatric nursing mandate is marginalised within a setting that is taken for granted as one of the primary sites of psychiatric nursing practice and therefore, of psychiatric nursing development. It is therefore hardly surprising that student psychiatric nurses experience this visibility/invisibility binary as a dissonance and a source of moral distress.

This next chapter uses some of the assumptions of social constructionism to account for the presence and workings of these discursive activities and to suggest how an understanding of psychiatric nursing based on these principles, might address the observed dissonance.

Chapter Five

Concluding Thoughts

5.1 Introduction

The rhetoric of modern psychiatric nursing theory holds the person-centred approach to be its quintessential essence. From a social constructionist perspective, this positioning suggests that the visibility of these meanings should be manifest in student psychiatric nursing conversations situated in helping contexts. The current study's analysis has shown that this is not necessarily the case.

The language in these texts is developed around a number of authoritative knowledge constructions about what can be said, when it should be said, how it can be said and when the saying time is over (Fairclough, 1992). Some of these constructions were identified in section 4.5.3 as descriptions of the to-be-expected psychiatric storyline and include a focus on the assessment of form of symptoms and on expressions of wellbeing and distress as normative markers of a functional assessment.

The authority of the professional in introducing and concluding the psychiatric agenda was shown to be all-encompassing. That these discursive activities manifest a symptom-like approach to nursing care and have the effect of disabling the development of client-authorized expressions of agency, is consistent with the outcomes of the many studies outlined in section 2.4.2 of Chapter 2 (Gijbels, 1995; Hopton, 1997; Latvala, Janhonen and Wahlberg, 1999; Lilja, Ordell, Dahl and Hellzen, 2004; Pieranunzi, 1997).

5.2 Interaction is a site of knowledge/power

The post-structuralist idea of knowledge/power outlined in section 3.3.7 1 offers some explanations for how it is that diagnostic-psychiatry knowledge constructions are manifest and person-centered principles marginalised as activities of student psychiatric nurse practice in these texts.

In the first instance, social power is conceptualised as a relational, capillary force, circulating through the social networks of a particular context, simultaneously enabling the visibility of some forms of knowledge as right and true, and disabling the legitimacy of others (Smart, 1985). Gergen (1999) argues that it is this discourse of the right and the true that legitimizes the exercise of power and its authoritative knowledge effects. Thus, in the case of these texts, the discourse of diagnostic-psychiatry circulates through the moral order of the clinic, in the language of these speakers, illuminating and entrenching these discursive practices as right and true, that is, as authoritative ways of being, knowing and doing in conversation.

In the second instance, a post-structuralist perspective of power/knowledge suggests that the sites at which meanings are generated are simultaneously the sites at which social power is exercised (Smart, 1985). Visibility articulates the connection between power and knowledge in that what is made visible in dialogue is both the source and site of knowledge/power. Thus, these episodes of nurse-client interaction are not simply the sites at which psychiatric meanings are manifest but also the sites at which the power/knowledge of this dominant discourse, rather than any other, is produced and reproduced in dialogue.

In the third instance, the exercise of knowledge/power is visible in its techniques and effects. The discursive doings of highlighting, herding and hectoring

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[1] This was outlined in the methodology chapter as one of the assumptions of the social constructionism underpinning this study.

may be conceptualised as three student psychiatric nursing disciplinary techniques through which the dominant diagnostic-psychiatry discourse is manifest as nursing knowledge/power and produced and reproduced in nursing conversations situated in the moral order of the psychiatric clinic.

In the case of these texts, interviewing and observation induces effects of power, that is, particular meanings and subject positions, through the ways in which it illuminates, regulates and normalizes difference in the direction of the dominant, to-be-expected psychiatric storyline (Gergen, 1999; Gilbert, 2002; McHoul and Grace, 1993). In this respect, these discursive activities work at the site of the nurse-client interaction and with varying degrees of force, in two ways. They work first to highlight the conversational subjects within their respective positions of authoritative, inquiring and judging nurse and passive, accounting and accepting client and then secondly, to normalise talk within the direction of the visible, to-be-expected psychiatric storyline (Adams, 2001; Smart, 1985).

In the fourth place, this analysis has shown that while there are traces of person-centred assumptions and client-authorised expressions of agency in these texts, the visibility of these assumptions has not been sustained sufficiently to manifest as knowledge/power (Gergen, 1999; Smart, 1985). This perspective of power suggests that the invisibility of these assumptions is related to the interplay between the forces of power and resistance in the process of meaning making. To this end, both nurse and client-authorised expressions of the life-world and of agency may be conceptualised as different and therefore, as potential sources of resistance to the free-flow of the dominant discourse (Haber, 1994).

In the case of these texts, the normalising effect of the discursive activities in the direction of the psychiatric storyline is increased when the potential for different meanings is encountered. To this extent, highlighting might manifest as herding or

hectoring when emerging meanings differ or depart from dominant to-be-expected psychiatric storylines.

What then, are the possibilities for a person-centred psychiatric nursing positioned within an institutional context whose ontology is both discursively powerful and different? In almost all of the studies outlined in section 2, the invisibility of the person-centered approach was taken to signify the need for further and more intensive interpersonal skill training and training in the dynamics of the person-centred approach. A social constructionist, positioning theory consideration of how the nurse and client might go on together in conditions of relationship might extend thinking about this person-centered rhetoric-practice gap beyond the cause-effect solution forwarded in the studies reviewed in chapter 2, section 2.4.

5.3 Social constructionist possibilities for developing person-centered sites of knowledge/power for psychiatric nursing

This recommendation or suggestion for a social constructionist understanding of one version of psychiatric nursing unfolds along three braided storylines. The first strand explores relationships as a site of knowledge/power transformation and how from a social constructionist perspective, the social meanings-positions of the to-be-expected psychiatric storyline might be transformed and in what direction.

The second strand explores why it is important for psychiatric nursing to trouble its own taken-for-granted constructs for their obvious, hidden and unintended effects and how this might inform the identity of psychiatric nursing as different psychiatric nursing personas in different contexts.

The third and final strand focuses on evolving expressions of client and nurse-agency through heeding dialogue.

5.3.1 Storyline 1: Relationships are sites of knowledge/power transformation

How then, is it possible for the nurse and the client to go on together in conditions of relationship situated in the moral order of the clinic so that the meanings-positions being jointly developed are evolving along mutually agreeable storylines, rather than inertly unfolding along a particular, to-be-expected path? The phrase to-be-expected is used in this context to reference conversational movement along disciplinary entrenched truths, psychiatric or person centered or other, and where these truths are used to police the unfolding of position-acts-meanings in the direction of these truths.

Social constructionism shows how some of the ideas from positioning theory might be used to manifest an account of psychiatric nursing that takes the power/knowledge effects of both the evolving conversation and it's culturally and other mediated contexts into account.

Gergen (1999) suggests that if meaning is jointly developed and manifest as power/knowledge in dialogue, then there is reason to honor relationships of meaning-making as a 'transformative' medium. The most obvious challenge to this assertion is what is meant by transformative and whether it is possible, within a social constructionist framework, to suggest what kind of psychiatric nurse-client meanings might have transformative effects.

Transformative dialogue is used here to reference the joint co-ordination of social acts-positions in evolving meanings that emerge as acceptable in conversation situated in context (Gergen, 1999; Harre and van Langenhove, 1999). The focus here

is on developing conversational actions that jointly evolve meaning rather than freeze it over in one direction or another, and that offer more promising ways of going on together in conditions of relationship (Gergen, 1999).

In this respect, social constructionism argues that because knowledge constructions are hierarchically arranged binary oppositions, both parts are discursively available and therefore, theoretically a resource for all to draw upon. From this perspective, it is theoretically possible that the antithesis of these bio-medical, psychiatric knowledge constructions is buried somewhere in these texts (Gergen, 1999; Phillips and Drevdhl 2003). The surfacing of these hidden binaries has the potential to at least de-stabilise dominant knowledge forms, thus creating the possibility for transformation in meaning-making.

It is therefore possible that the surfacing of these meanings in dialogue might offer mutually acceptable ways of going on together (Gergen, 1999). If this is the case, then a sense of the novel and the unexpected might be the oppositional pair of the to-be-expected psychiatric storyline. Likewise, a focus on the exploration of content and meaning of personal experiences might be paired with a focus on the assessment of form of experience. Similarly, human responses as potential needs to be addressed may be oppositionally paired with human responses as normative markers of psychiatric wellbeing assessment. Finally, the authoritarian, expert position of the professional in deciding these matters might be usefully paired with the self-authored, expert position of the client in deciding these same matters.

Since these oppositions are more closely aligned with the person-centred approach, it would be convenient to suggest that ways other than re-training be found to manifest the power/knowledge of this approach in practice. For example, suggestions for how strategies based on cultural and emancipatory theories, such as political activism, might be used to manifest psychiatric nursing as a distinct entity have been forwarded (Hopton, 1997; Gilbert, 2001 and 2002). This and other

strategies might be useful in surfacing these experience-oriented hidden meanings in dialogue situated within diagnostic-psychiatry ontology. Reflective journaling that uses the triad of positions-storyline-social actions to analyse written entries might help students to move across contexts in their thinking about how actions-positions-nursing meanings is constituted in and by the social forces circulating within the moral order and through its specific activities. This might also help them to understand that just as knowledge is generated in the things they do and say so are sayings and doings the site of transformation and difference.

However, the invisibility of person-centred assumptions in these texts is not simply a consequence of their being disabled through their unequal power/knowledge relations with the ontology of the psychiatric clinic. Social constructionism argues that evolving promising ways of going on together in conditions of relationship are not just a matter of finding new conversational actions but of looking at how the conversational mandate might destabilise itself (Gergen, 1999; Smart, 1985).

5.3.2 Storyline 2: Surfacing the disabling effects of our own rhetoric

Transformative dialogue for these texts is therefore not just a matter of surfacing the hidden but of surfacing how the construction of particular disciplinary meanings might inadvertently disable their visibility in episodes of psychiatric nursing conversations (Gergen, 1999; Mishler, 1984).

The person-centred discourse frequently positions the nurse as the instrument of care and the client as the site at which this care is articulated (Jacobs, 2001; Hopton, 1997; Newman, 2002; Thorne, Canam, Dahinten, Hall, Henderson and Kirkham, 1998; Young, 1989 and 1999). One of the unintended effects of this a-priori positioning is the extent to which it polarizes the nurse at the active end of the 'nursing as instrument' binary and the client at its passive and receiving end.

Likewise, illuminating the client as the site of care polarizes the client as the object of nursing action and the nurse as the originator of this action. There is therefore very little opportunity within these speaking positions for collaborative, client-centred meaning-making, that is, for the articulation of the person-centred mandate of nursing.

It was suggested in section 2.4.3.1 that person-centred assumptions have been reified as incontestable truths in psychiatric nursing language and therefore, set outside the bounds of scrutiny (Jacobs, 2001; Hopton, 1997; Newman, 2002; Thorne, Canam, Dahinten, Hall, Henderson and Kirkham, 1998). The social constructionist point here is that thinking about how psychiatric nursing should manifest must also consider its own person-centered and other truths for their potential disabling effects on evolving mutually agreeable ways of going on together in episodes of student nurse-client interaction.

This reflective position might serve as a useful starting point for a dialogue with students about how and why dominant knowledges become visible in a particular practice setting while other equally valid forms, are marginalised. One of the tasks for the problem-based approach to nursing would be to consciously extend exploration of the problem to what is visible but also, to what may be potentially hidden, including dimensions of the person-environment interface. Having both binaries as the goal of problem-based learning would require extended dialogue with clients and the theoretical texts of psychiatric nursing.

This is not to suggest that psychiatric nursing's already well-developed framework is without substance. If the social constructionist understanding of the self is extended to an understanding of four of psychiatric nursing's metaparadigms concepts – the client, the nurse, nursing and the environment - then their already well-developed biographies (cultural, social, political traditions, knowledges, practices) are a rich and necessary resource for and source of its on-going

development. Thus, each paradigm might be conceptualised as both the singular identity of their biographical and other socially and culturally mediated qualities within and across time and space, and as a multiplicity of public personas - a coherent cluster of traits - that are manifest in conversation (Gergen, 1999).

It is possible to suggest that the knowledge constructions at work in these texts are a partial presentation of one of the public personas of student psychiatric nursing – the psychiatric, bio-medical persona - manifest in dialogue situated in the moral order of the psychiatric clinic (Davies and Harre' 1999). It would also be possible to suggest that psychiatric nursing's recourse to these constructions is appropriate to nursing's long history of relationship with the bio-model and a necessary aspect of the biography of the community-based psychiatric client. On the other hand, the analysis of the discursive doings of these texts has shown that these psychiatric meanings and therefore, these personas, are not mutually evolved in interaction but frequently coerced.

5.3.3 Storyline 3: Evolving client and nurse-agency meanings in psychiatric nursing

The discursive activity of heeding offers one promising way of the nurse and client going on together in conditions of relationship. This conversational activity might help unfreeze meaning-making in those nursing conversations where analysis suggests that particular meanings are being coerced rather than jointly evolved. The term heeding was used in section 4.4.3 to describe the social effect of the conversational sequences wherein instances of client-agency are manifest and sustained as intelligible actions of self-authorisation in episodes of interaction.

Because client-agency is used to reference the orientation of the client to the doings of self in conversation, it is to these doings that the activity of heeding is directed. Thus, if the client-speaker's orientation to his/her biographical self includes

a psychiatric focus, then this is the meaning that for the moment is pursued and sustained in the unfolding dialogue. Conversely, if the client-speaker's orientation to self is unavailable in dialogue, then this unavailability is read and affirmed as a form of agency manifest in intentional self-positioning and with specific effects for the unfolding meaning. Accountability for what meanings/social actions are being generated is therefore relational rather than individual and constitutes and is constituted by the unfolding dialogue (Gergen 1999).

The idea of relational accountability suggests that if potentially troubling experiences are known to be active in the client's life but are not manifest as meaning in dialogue then their unavailability rather than the experience itself is the source of meaning-making for the moment. This relational understanding of going on together might go some way to articulating how the core psychiatric nursing category of 'knowing me, knowing you' described by Jackson and Stevenson (2000) might be expressed in interaction with clients. Every moment with the client need not necessarily be a moment of confession for the client; the type of moment is defined by the client-authorised meanings being jointly established in dialogue.

The idea that the nurse-client relationship is not only the site at which knowledge is generated but also the site at which prevailing knowledges are made visible against the backdrop of the invisible and entrenched as truth, is a very powerful one. This kind of understanding might help students to locate their feelings of responsibility for the invisibility of person-centred principles in their practice in the dialogue-context interface rather than in themselves as evidence of bad practice. This is not to imply that individual responsibility is abrogated; the idea of dialogue has been repetitively constructed as including the biographies of those involved.

If the identity of nursing were to be actively presented first and foremost as relational with different skill-based personas, then this identity might background the particular personas each practice instance and setting calls into being. The idea

of being called into being illustrates the constitutive effects of broader social practice. If students were to be actively aware that how they go along together with clients in conditions of nursing is constituted in and by a range of competing social forces such as the dominant institutional practices and goals, their own biography of nurse, their educational programme and the biography of the client, they might be more able to critically reflecting on how certain practices become more visible. In the case of these texts, understanding how some practices are visible as knowledge and others not (in spite of their best intentions) might go some way to contextualising their experience of the rhetoric/dissonance gap in the dialogue-context interface.

The clinic-interview is a legitimate site of psychiatric knowledge generation. The issue is whether it is also possible for this to be a site at which psychiatric nursing knowledge is generated. If psychiatric nursing knowledge were understood to be one of the outcomes of a heeding approach, then the reasons for the nurse and client meeting would be openly displayed, set out and negotiated. In this case, the nurse would actively call the psychiatric persona into being: "*You have come to the clinic to collect your psychiatric medication. You know that we briefly look at how your medication has been working over the last month, if it is doing what it is supposed to do and if you have any problems with it*".

If this were the case, the psychiatric interview could unfold easily and legitimately and along more structured psychiatric lines, such as for example, along the mental state examination, and/or the diagnostic interview. The use of these tools could simultaneously be used for client teaching. Murphy and Moller (1993) suggest that clients who use the language of the profession in their encounters with professionals are more likely to be taken seriously and their relapse concerns attended to: "*We ask you all these questions from a tool we use to see what symptoms might be present or absent – mental state examination. All your symptoms fall into this group of symptoms which is what people with the diagnosis of Schizophrenia usually have*". The idea

here is that if the psychiatric persona is called into being, then it should be the best persona it can be within the context of current psychiatric knowledge and practices.

These texts have shown that clients do raise life-world issues, the territory of the person-centred approach. However, clients do not always want to talk and this client-centred approach has been recently criticised for its privileged assumption that psychiatric nurses must help clients to talk about (excavate) their problems (Jonsdottir, Litchfield and Pharris, 2004; Shattell, 2004). This suggests that the nurse will have to move between two to three personas in her working with clients in this context. It might be possible to set this as the agenda in the first moments: "*You have come to collect your medication ... lets work thorough the first task of seeing that medication-wise, you are ok and then lets leave some time spare to talk if you would like*". In this way, both dominant and potentially marginalised ways of being are recruited into the conversational space and discursively available for the participants to draw upon. Clearly, the nurse's dialogue would have to attend to and to sustain the idea of heeding if dialogue is to be client-authorised.

It is possible that in these and many other ways, the principles of the human-centred tradition of nursing may be integrated in the process of meaning making and not set apart as truths to be measured up to and against but rather, as guiding values that guide for the moment.

5.4 Conclusion

The nurse-client interaction is privileged as the site and source of knowledge in modern psychiatric nursing theory. These texts are a source of knowledge but the kind of knowledge being developed here is not consistent with the person-centred ways in which the profession defines its knowledge and practice activities (Ingles, 1966; Forchuk, Martin, Chan and Jensen, 2005; Peplau, 1952; Shattell, 2004).

The visibility of the to-be-expected psychiatric storyline with its asymmetrical speaking positions in psychiatric nursing dialogue is on the one hand quite astonishing and on the other, unremarkable. What makes it astonishing is that if the criterial doings of person-centred practice or heeding are used to warrant the characterization of nursing practice, then practice in these texts can not be said to be nursing. It might better be conceptualised as psychiatric assistance. What makes it unremarkable is that this issue has been consistently explored in the literature and one of the motivations for a person-centered approach in the first place, was to address precisely this problem (Curry, 1995; Dzurec, 2003; Jonsdottir, Litchfield and Pharris, 2004).

The implication of the visibility of dominant psychiatric knowledge constructions in these texts may be significant, not only for these texts, but also for the development of psychiatric nursing in public health clinic-based contexts where a similar ontology prevails. If social meaning is jointly developed and manifest in dialogue situated within a particular moral order of speaking, then these discursive doings cannot simply be dismissed as invalid or as 'non-nursing' because of their closer association with bio-medicine than the psychiatric nursing mandate. These doings and the relative invisibility of the person-centered approach must be made visible as one account of what it is that student psychiatric nurses do in nursing conversations situated in this clinic-based context.

Transcript Number One (1) Interview Duration: 3 minutes

Additional Transcription Notes ((Nurse's tone of voice is quiet and respectful. Both client and nurse seem matched with respect to speech tone, volume, pacing and pausing.))

1	1.1	Q	Nurse: ((OIS))	How have you been doing ***during the last*** month?
2		A	Client:	I've been fine (.) much better.
3	1.2	PRaeq	Nurse: ((CIS))	Much better? ((Pages being turned)) Mm:: (1 sc).
4		A	Client:	I'm eating well (.) I'm sleeping well.
5				
6	2.1	PRaQ	Nurse: ((CIS))	Sleeping well? (.5) Okay (.5) and (.) at home?
7				(Pages being turned))=***Where do you stay***?
8		A	Client:	In ((names local town)).
9	2.2	PReq	Nurse: ((CIS))	***Who do you stay with*** there?
10		A	Client:	I stay with my family my wife and (.) and one son.
11				my married son stays in our house (Nurse: Okay)
12				my daughter is married (.) they look after me.
13				
14	3.1	PRaQ	Nurse: ((OIS))	So (.) tell me about your ***relationship*** (.) I mean (.)
15				within the ***family*** (.) all of you (.) how do you:: (.)
16				live(.) with each other?
17		A	Client:	Oh: we get well (.) we get on very well.
18				Nurse:Okay.) I have good children. They look after
19				me. We get on nicely (Nurse: Okay, I see) sometimes (.)
20				you know how it is (.) families do
21				have a small argument but that's not worth a fight.
22	3.2	PRaeq	Nurse: ((CF))	Yes (.) okay (.) so you seem to be taking (.) to be (.)
23				all the more (.) with your family (.) able to handle
24				everything?
25		A	Client:	Ja:: much (.) much so (2sec) and the children will
26				Look after me. They (.) they (.) like my daughter
27				and my son that's working they (.) contribute
28				towards the house like groceries (Nurse:Okay,
29				okay) I'm not working at the moment.
30				Nurse:Okay) (.5) It's not so e::asy but its (.) okay.
31	3.3	PReq	Nurse: ((CF))	So you're saying it's not easy staying at home (.)
32				not working?=
33		A	Client:	=Ja especially when you don't work hey? and you
34				need money (Nurse: Mm::) you know?
35	3.4	PReq	Nurse: ((CF))	Mm:: I see (.) so you are saying but that (.) but
36				otherwise your children they make it easier for you?
37		A	Client:	Much (.5) very much so hey?

4.1	PRaQ	Nurse: ((OIS)	Okay (.) alright (.) how's your ***medication***?	
	A	Client:	Ja, my medication is helping me. That's what I've come for now ( ) I'm going to see the doctor in:: what? May? June? (Nurse: June 26th.)	
4.2	PRaQ	Nurse: ((CIS))	So (.) no set backs (.) nothing ?	
	A	Client:	Well I've had stomach pro::blems but (nothing much).	
5.1	PRID	Nurse: ((ID))	Okay (5sec) um (.)I'll put you for the ***next appointment*** (4sec) and (.5)it should be (public holiday)(3sec) you are comfortable with Wednesday or (.) (Client: Ja, Wednesday) Okay (.) It will be a holiday on Wednesday 1st so it will be Thursday 2nd. (Client: Ja, that's fine(2 secs) 2nd May.) (5sec)That's fine(.) then you can go and get your medication now.	
	A	Client:	Thank you (Nurse: Thank you) Bye (Nurse: Bye.).	

Tape ends

Transcript Number Two (2) **Interview duration: 5 minutes**

1	1.1	Q	Nurse: ((OIS))	S::o then how are you ***today***? (Client:Okay) (.)
2				then is there anything you want to ***talk about***?
3		A	Client:	(.5) Not really sister.
4				
5	2.1	PRaQ	Nurse: ((CIS))	Mmm (.) so:: concerning your ***medication***, are
6				you still taking your medication?
7		A	Client:	Yes, I'm taking it three times a day. Urr:: in
8				the morning, at lunch and at supper.
9	2.2	PReq	Nurse: ((OIS))	And the:n (.) how are the side-effects of the
10				medication?
11		A	Client:	(.2) It's hel:ping but er:: (.) you see I've (.)
12				they're giving me a different type of medication
13				here. I used to go (Street) clinic <u>first</u>. So (.)
14				they tell me like six months I get the tablets
15				and after six months I don't get the tablets. So
16				they give me something else in return. So that
17				is why I came here.
18	2.3	PRaeq	Nurse: ((CIS))	So::o (.) what were you getting in the (.) in the
19				clinic you were attending?
20		A	Client:	I was taking the other white er:: tablets, the
21				White tablets (Nurse: Mm::) but now they are
22				giving me the other one (.) the orange (Nurse:
23				Mmm::) pill.
24	2.4	PReq	Nurse: ((CIS))	<u>Ja:::</u> (.) but it's <u>helping</u> you?
25		A	Client:	(.2) J::a, I guess so ((laughs softly))
26				
27	3.1	PRaQ	Nurse: [[CIS]]	Okay ((Laughs softly)):: (.) so:: (.) **is there anything**
28				**that is troubling** you?
29		A	Client:	(.5) Not really (Nurse: Mm::) I suffer with my
30				head as well.
31	3.2	PReq	Nurse: ((CIS))	And then (.) did you see your doctor about
32				that?
33		A	Client:	(1 sec) N::o (.) I didn't see the doctor for this I
34				suffer with tension.
35	3.3	PRaeq	Nurse: ((CIS))	Mm: (.) so then have you ever went to (names
36				General hospital)) because the Doctor might not
37				help you here=
38		A	Client:	=I've <u>never been to a hospital</u>. I normally buy
39				the tablets from the::: (.5) this thing (.) surgery
40				across from my place. I buy the tablets and I

Highlighting

Herding

Herding

41				uhh. I normally buy pain tablets (.)but it doesn't
42				seem to be helping. You=s::ee I have a little boy
43				and (.) um (.) my boy friend (.5) and you know (.)
44				he gives me problems now and again too.
45	3.4	PReq	Nurse: ((OIS))	What problems (.) what problems does he give?
46		A	Client:	(.5) He's always (.) like (.) fighting and arguing
47				(.) and stuff like that.
48	3.5	PRaeq	Nurse: ((OF))	With you? And then (.) how does that make
49				you feel?
50		A	Client:	(4sec) I told him that if he, he wants to be
51				separated, he is welcome to do so because I'm
52				ay:: (.) I'm one person that (.hh) I can't stand
53				nonsense. (Nurse: Mm::hh) That is why I
54				suffer with my head [Nurse: What did he say?]
55				it's the tension=
56	3.6	PReq	Nurse: ((OIS))	=What did he say then?
57		A	Client:	Mm:: (.) he doesn't wanna say anything, he
58				doesn't want to leave me (Nurse: Mm::) (.2)
59				You s::ee I'm living with my aunty (Nurse: Ja)
60				I don't have a place (.) of my own.
61	3.7	PRaeq	Nurse: ((CIS))	Mmm:: (2 sec) So:: (3sec) Anyway. (.5) Is it
62				better now?
63		A	Client:	(3sec) Ja, .hhh ((laughs softly)) it is but I would
64				prefer a place of my own=
65	3.8	PRaQ	Nurse: ((CIS))	=Ja (2sec) I understand. So you say otherwise
66				there isn't anything that's troubling you?
67		A	Client:	Otherwise, no.
68				
69	4.1	Prq	Nurse: ((CIS))	Mm:: (.) So (.) are you are still ***sleeping well***
70				***and eating well?***
71		A	Client:	I generally don't sleep well.
72	4.2	PReq	Nurse: ((OIS))	Then can you tell me more about it?
73		A	Client:	.hh (.) I've been taking sleeping pills to help me
74				Make me sleep but still.
75	4.3	PReq	Nurse: ((OIS))	For how long has it been happening?
76		A	Client:	A:: couple of months.
77	4.4	PReq	Nurse: ((CIS))	At what time did you go to bed?
78		A	Client:	I sleep early, (Nurse: Mmhh) I'm in bed by six.
79				We normally sleep at six.
80	4.5	PReq	Nurse: ((CIS))	Then: (.5)what time did you wake up (.) midnight?

Hectoring

81		A	Client:	Mm:: (.) Ja, sometimes I don't sleep at night
82				huh (.5) I'm awake half the night (Nurse: Mm::)
83				because the: (.) the tablets I have been taking
84				don't seem to be helping me (Nurse:Mm::) even
85				the sleeping tablets don't really make me to sleep
86				at night.
87	4.6	PRIDq	Nurse: {(CSo)}	So:: do you wanna to change maybe you should change
88				your sleeping habits then maybe sleep at abo::ut
89				nine o'clock?
90		A	Client:	(3sec) I can't sleep late ((laughs softly, nurse
91				Also laughs)).
92	4.7	PReq	Nurse: ((OSo))	Okay (soft laugh)) hhh so:: (.5) what do you
93				suggest you will do then?
94		A	Client:	(2sec) ((Laughing softly)) <u>You</u> should tell <u>me</u>.
95	4.8	PRaID	Nurse: ((ID))	((Laughs softly)) Well I suggest that you (.) go
96				to sleep later then, ja::, <u>maybe</u> (Client: Mmm:)
97				it might help you(.) <u>ja.</u>
98		A	Client:	Sometimes when I go to sleep to:: (.) I can't
99				sleep because of these pains that I've been
100				getting you (Nurse: Mmm) know.
101	4.9	PRID	Nurse: ((ID))	(2sec) Then I suggest that maybe you (.)
102				should go to see a doctor then=
103		A	Client:	=I'm under a lot of stress <u>too</u> (.) you see.
104	4.10	PReq	Nurse: ((CIS))	(2sec) Then what (.) Okay (.) What (.) about
105				your boyfriend?
106		A	Client:	He gives me too much problems, <u>too much</u>. He
107				((boyfriend)) worries me <u>a lot</u>.
108	4.11	PraID	Nurse: ((ID)	(5sec) Ja, I see (4sec) but I suggest that you go
109				(.) to (.)bed later than (.5) later than six.
110				Maybe at nine (.) or eight (.5) then maybe (.) it
111				might help you=
112		A	Client:	=If I go to sleep early I get up early.
113	4.12	PRaID	Nurse: ((ID))	Oka:::y (2sec) Oh (2sec) So then (.5) try <u>that</u>=
114		A	Client:	=Try and sleep later?
115				
116	5.1	PRaID	Nurse: ((ID))	<u>Ja</u> (.) I think it might help you (3sec). Anyway,
117				thanks again. ***See you next time***. Then I will
118				write your return date it is on the 23rd of (tape
119				ends)

Highlighting

Transcript Number Three (3) **Interview duration: 3 minutes**

Additional transcription notes/details

((There is a loud background noise on this tape making some of the recording unclear. Occasionally the voices are distorted))

1	1.1	Q	Nurse: ((OIS))	You look so nice Mr ((X)). ***How can I help you***?
2		A	Client:	Umm:: I'm here for my tablets, nurse=
3	1.2	Preq	Nurse: ((OIS))	=How have you being ***doing in the last month?***
4		A	Client:	O:h (.) Pretty well. I was feeling much better
5				[Nurse:Coughs] (.) especially with the [Nurse:
6				Coughs]tablets.
7				
8	2.1		Nurse: ((OIS))	How are your ***sleeping patterns (.5) and eating*** also
9				(.5) comparing to prior to your
10				((medication))?
11		A	Client:	Oh (.) I've been sleeping afternoons (.) at home
12				but this afternoon this meeting was organized. I
13				also eat small foods.
14	2.2	PReq	Nurse: ((CIS))	When did sleeping afternoons started?
15		A	Client:	(2sec) Oh:: (.5) last week.
16				
17	3.1	PRaQ	Nurse: ((OIS))	Okay (.) ***where do you stay*** Mr ((X))?
18		A	Client:	I'm around ((names town)) and (.) ((names
19				suburb)).
20	3.2	PReq	Nurse: ((OIS))	You mentioned that you stay at home. ***Who do***
21				***you stay with***?
22		A	Client:	I stay with my wife and my second daughter (.)
23				And the last one (.) my last one (.)
24				((name deleted))(.5) but I got a first one (.) my first
25				one is married now (.) she got married two years
26				ago.
27				
28	4.1	PraQ	Nurse: ((OIS))	Okay (5sec) how do you and your ***family cope***
29				with (.) ((life or like)) ***expenses***?

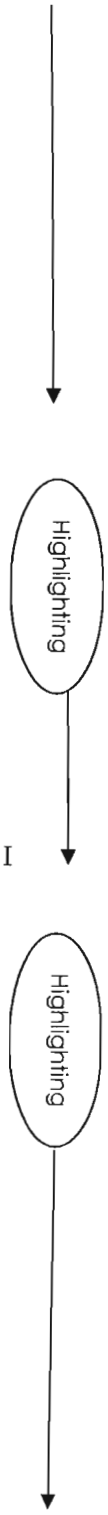
Highlighting

Highlighting

Highlighting

Highlighting

30		A	Client:	I get government grant and my daughter is a
31				teacher in((names suburb)) so she supports us.
32	4.2	PraQ	Nurse: ((OIS))	You also mentioned your wife (.) what is she
33				doing?
34		A	Client:	She was working at ((General)) hospital but she
35				left her job since I got sick. She wanted to look
36				after (.) myself.
37	4.3	PReq	Nurse: ((OIS))	What are you doing before you got sick?
38		A	Client:	I was working (.) as a clerk at (( )) then I lost
39				Concentration on my work and (.) hearing so::
40				many voices ( ).=
41				
42	5.1	Prq	Nurse: ((OIS))	=Can you tell me how is ***relations in the***
43				***family***?
44		A	Client:	Oh it's uh:: (.) pretty well. We respect each
45				other no matter if you young or old but (.) we do
46				respect each other=
47	5.2	Preq	Nurse: ((OIS))	=How ((does family)) understand your
48				condition?
49			Client:	Oh I think (.) much better (.) I mean (.) they
50				understand (.)I mean(.) they understand it more than I
51				thought=
52				
53	6.1	Prq	Nurse: ((OIS))	=So how is ***your tablets helping***?
54		A	Client:	It helped me a lot. I'm sleeping a lot, eating a
55				lot and I think everything is going:: very well.
56	6.2	PReq	Nurse: ((OIS))	How do you take your tablets?
57		A	Client:	I take one (.) tablet twice a day (.) from one
58				packet and I take one three times a day from
59				the other packet.
60	6.3	PRaeq	Nurse: ((CIS))	Oh (.) okay. Do you experience any side effects
61				from the tablets?
62		A	Client:	(2sec) I used to (.) before (.) but now I think uh::
63				everything is okay (.) but it's uh:: I think it's
64				uh:: it's only uh::: I used to (.) go toilet only once
65				after three days I think that is the only side-
66				effect I have been experiencing=

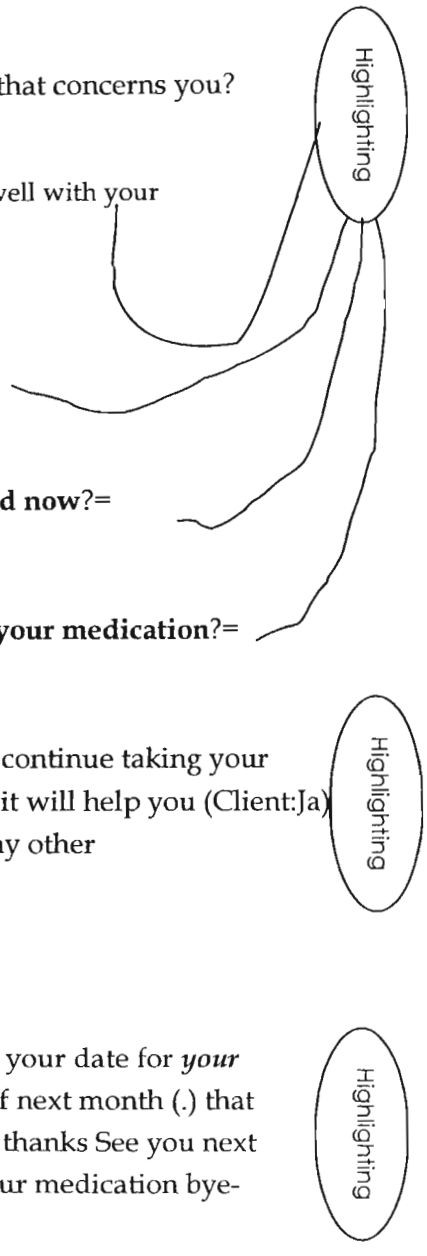


67	6.4	PRaID Nurse: ((ID))	=Okay (.) I can give you advice for that. Maybe	
68			you have to increase your fruit (.) (Client: Mm::)	
69			okay? (.) eat fruit (.) (Client: Mm::) and exercise	
70			(.) maybe (.) twice a week. It can help you (.)	
71			with your bowels (.) function (okay?).	
72		A Client:	Oh (.) okay, thanks nurse.	
73				
74	7.1	PRaID Nurse: ((ID))	Okay, your ***next appointment date*** will be 9th	Highlighting
75			October.Is it okay? [Client: It's okay] Do you	
76			have ***anything else*** you wanted to talk about?	
77		A Client:	No::: not as yet (.5) nothing.	
78	7.2	PRaID Nurse: ((ID))	Okay (.5) so I think (.) you can wait over there	
79			for your tablets.	
80		A Client:	Thank you for your co-operation (Nurse: Thank	
81			you for your co-operation) thank you sister.	
82	Tape Ends			

Transcript Number Four (4) **Interview duration: 50 seconds**

((Nurse talks very quickly and the patient quietly))

1	1.1	Q	Nurse: (OIS))	Okay (.) ***any issue of concern*** that concerns you?
2		A	Client:	Nothing=
3	2.1	PRaQ	Nurse: ((CIS))	Okay (.5) are you still (.) doing well with your
4				**medication**?
5		A	Client:	Yes.
6				
7	3.1	Prq	Nurse: ((CIS)	**Sleeping well, eating well?**
8		A	Client:	Yes.
9				
10	4.1	PraQ	Nurse: ((OIS))	Okay (.) How is **your husband now**?=
11		A	Client:	=He's alright (.) alright.
12				
13	5.1	PraQ	Nurse: ((CIS))	Okay (.5) **then you came for your medication**?=
14		A	Client:	=Yes
15				
16	5.2	PRaID	Nurse: ((ID))	(3 sec) Okay (.5) you must (.) continue taking your
17				medication well (.) so that (.) it will help you (Client:Ja)
18				so you will no longer have any other
19				problems, oka::y?=
20		A	Client:	=Yes.
21				
22				
23	6.1	PRaID	Nurse: ((ID))	=Okay, I'm going to check (.) your date for ***your
24				*Next visit*.** It will be on 15th of next month (.) that
25				is April.(Client: Okay.) Okay thanks See you next
26				time. You can go and take your medication bye-
27				bye.
28		A	Client:	Thank you.
29	Tape ends.			
30				



Transcript Number Five (5) **Interview duration: 11 minutes**

Additional transcription notes/details

- This client speak very quickly, running sentences together. There is more interruption ([ ) between the speakers in this text than in the others.The nurse speaks calmly, clearly and with concern.

1	1.1	Q	Nurse: ((OIS))	***How have you been[***
2		A	Client:	[I'm alright. When I take the
3				tablets I'm fine.
4	1.2	PRaeq	Nurse: ((OIS))	Is it? If you don't take your tablets what's[
5		A	Client:	[If I don't
6				take the tablets then I (.) I (.) I be"naggy" [Nurse:
7				Naggy, what's?] (.) like (.) you know (.5)like (.)
8				especially with my wife, you know (.) I say you didn't
9				do this you didn't do that[
10	1.3	PReq	Nurse: ((CIS))	[You argue a lot?
11		A	Client:	[Then uh when my wife
12				Ask me, "Did you take your tablets?" I say "No I
13				didn't take my tablets." So what happened now
14				(.) I go and take my tablets and after a little bit
15				while (.) then I be good with my wife and I talk
16				to her (.) I be nice. (Nurse:Okay) But if I don't
17				take my (.) sometimes I forget you see (Nurse:
18				Mm)sometimes I'm very forgetful and I don't
19				take my tablets I be naggy with her (.) I'm
20				telling her "Oh, you didn't do this, you're not
21				worried about me, this and that". Then she
22				reminds me. She says "Go take your tablets" so
23				I did I go take my tablets and I talk nicely
24				(Nurse: Okay,that's nice) This morning I took
25				tablets.
26	1.4	PraID	Nurse ((CID))	Okay, so now you know how important it is for
27				you to take your tablets?.
28		A	Client:	Ja it's very important. That's why before I can
29				come now (.) my wife says take tablets. So I
30				take tablets and I came and I'm talking to you
31				nicely but for outsiders now (.) if I (.) if I go (.) if

Highlighting

32				take a walk (.) I won't talk to anybody (.) I'll stay
33				quiet (.) (Nurse: Mm) I don't (.) I'll stay very quiet,
34				you know? And uh (.) I'll be a bit depressed too.
35	1.5	PReq	Nurse: ((CIS))	After you take your tablets (.) you become quiet?
36	A	Client:		I become qui::et and I talk ni::cely like I'm talking to
37				you now (.) but I don't swear and all[
38	1.6	PReq	Nurse: ((CIS))	[Do you swear if you don't take your tablets ?
39		A	Client:	[NO (.) I'm not vulgar (.) no (.) I'll tell my wife
40				Oh, I asked you for a cup of tea (.) you didn't give
41				me(.)how long you taking for a cup of tea?" Now I
42				don't realise she's too busy, you know? So when I
43				don't take my tablets I say "How long I ask you for a
44				cup of tea. What's wrong with you? Why did you move
45				my tea?" Then my wife asks "You took tablets?" I say
46				no and I go take the tablets and then I say "Oh I"ll
47				make my tea" (Nurse: Mm) Things like that (Nurse:
48				Okay)but it upsets me if I don't take my tablets
49				(Nurse:Okay) Ja, I get upset.
50				
51	2.1	PRaeq	Nurse: ((CIS))	So: last month nothing happened then, ***you took your***
52				***tablets*** and (.) you were fine last month ((the
53				medications () fine))?
54	2.2	A	Client:	You see: (.) what happened (4sec) uh: (.) this
55				(tokolosh) somebody put ((it)) (Nurse: What's
56				tokolosh?) that thing (.)you know (.) he talks to me
57				inside (Nurse:Mm) he talks tome inside, ja. The first
58				time I (.) I (.) I didn't know this (.) he's talking to me
59				and=[
60	2.3	PReq	Nurse: ((CIS))	]Who is this:: (.) (Client: uh?) Is this a person
61				talking to you?
62		A	Client:	No (.) you see what happened uh:: somebody
63				told me (.)that I must take Uh salt water (.) (Nurse:Mm)
64				in a cup of uh:: (.) ((palizer)) (.) right? (Nurse:Mm) (.)
65				and a small black thing came out (.) like a fungus
66				(Nurse:Mm) and I (.) I spewed that in the toilet
67				(Nurse:Mm) and the toilet was nice and clean. White
68				like this paper. Then I drank (.) that (.) I drank that salt
69				water and people said I must keep
70				drinking the water until I get full. I (.) I (.) Then I see
71				this <u>small</u> thing came out, you know? I looked at that
72				one there (.) I should have taken it out and put it in a

Herding

73				bottle (.) but I flushed the toilet. You see (.) that one
74				was controlling me.It made me go scream under the
75				garage (.) and by the shopping center and all, you
76				know it made me scream and I ran away to ((names
77				suburb)) (.) because that thing (.) that thing pushed
78				me out of the house (.) and at nighttime (.)when I
79				scream it was terrible (.)I turn this way then my
80				mattress go up and down, up and down and then it
81				chased me out, you know and then its running on my
82				this thing () I mean nothing (.) you see and after I
83				palizer that thing (.) then I came (.) all right now (.)
84				now I stay at home now and I don't run outside
85				nothing, I stay (.)and the doctor gave me some uh:
86				tablets too. He reckons to try and put it right (.) but
87				now see (.) the sleeping tablets he gave me (.) I'm
88				sleeping nice (.) and urr. now I'm having peaceful.
89	2.4	PRaeq	Nurse: ((CIS))	Do you hear voices then?
90		A	Client:	No, its ringing in my ears, sister.
91	2.5	PReq	Nurse: ((CIS))	You hear people talking to you?
92		A	Client:	No, no, its ringing, you know like uh (.) you know like
93				siren? (Nurse: yes). Like assuming (.) like uh (.) like
94				now there's a building catching on fire (.) and there's
95				((clientmakes a sound like constant high pitched
96				ringing for 4sec)) (laughing) ringing in my ears.
97	2.6	PReq	Nurse: ((CIS))	Is it ringing now?
98		A	Client:	Ja it's ringing (.) it's still ringing in my ears=
99	2.7	Preq	Nurse: ((CIS))	=Now too?=
100		A	Client:	=Ja, now too=
101	2.8	Preq	Nurse: ((CIS))	=Even if you took your medication its still ringing?=
102		A	Client:	=Ja, if I (.) if I a took my medication it's still ringing
103				(.)now too it's ringing. I don't now which ear (.) this
104				ear or this ear (.) I don't know which ear.
105	2.9	PReq	Nurse: ((OIS))	If it's ringing do you:: (.) cover your ears and what
106				do you do if it's (.) if it's ringing like that?
107		A	Client:	Uh (.) what's that sister?
108	2.10	PReq	Nurse: ((CIS))	Do you block when it's ringing like now=
109		A	Client:	=It's ringing (.) No (.) if I block (.) I don't know (.) I
110				don't know it's still ringing=

111	2.11	PReq	Nurse: ((CIS))	=It's still ringing?=
112		A	Client:	=It's still ringing (.) ja.
113	2.12	PReq	Nurse: ((OF)	(2sec) Do you get upset about that=How does it make
114				you feel?
115		A	Client:	For what sister? (Nurse: The ringing) No I'm used to
116				it now. Before I used to get upset, you know (.)but
117				now I'm used to it and I told the doctor (.) I got this
118				ringing and all. Now all the sisters know (.) but one
119				sister I spoke to (.) one Indian sister (.5) she told me
120				she was going to ((general hospital)), you see. She told
121				me (.) when I told her the ringing in my ears (.) she
122				says "Oh, I feel sorry for you" and I asked her for
123				wh:at (.) and (.) uh:: she stayed quiet and walked
124				away. I wonder why she said "I am sorry for you"
125				when I told her about the ringing in my ears?=
126				((Papers shuffling)) [Nurse: Mm:(.) so your wife is fine
127				everyone is fine?]=
128				=YOU KNOW SOMETIMES (.) SOMETIMES THE
129				RINGING IN MYEARS (.) I can't hear you talking (.)
130				then I ask you "What,what?" You see (.) some people
131				get angry (.) when I ask them "What, what you said?"
132				Because you know why (.) this ringing (.5) I'm
133				hearing part of the ringing and hearing you (.) so half
134				and half, you see.
135	2.13	PReq	Nurse: ((CF))	So you hear two things together (Client: Ja, ja) and
136				it's hard for you?=
137		A	Client:	=Ja, ja (.) like sometimes ask me a question and I say
138				"What you say?"(.5) cause you know why it's the
139				ringing obstructing it(.5) so I can't get your:: words in
140				my ears.
141	2.14	PRaQ	Nurse: ((CIS))	Oh, okay Mr (X) (.) so that's just what has happened
142				last month (.) and so (.) the medications they are (.)
143				okay?
144		A	Client:	Ja:: the medication is okay.
145				
146	((Someone comes in to ask the nurse for another clients file. It sounds as if the tape is stopped			
147	and then re-started. The client's utterances in lines 148-150 have no preceding context and I			
148	would speculate the client began talking into the conversational gap created by the			

149 interruption about his ears and with which he is currently conversationally occupied.))
150
151 A Client: Dr.((X)) sent me to ((names General Hospital)) he
152 says I must go for an ear check, when I went there
153 they put a pipe and nothing is wrong so[
154 3.1 PRaID Nurse: ((ID))]***Okay so the ringing*** (.) now
155 it's just a part of the mental illness hey?=
156 A Client: Ja (.5) You see what happened sister (.) I'll tell you (.)
157 you see what happened (.) I was supposed to get
158 married to a family girl (Nurse:Mm) like a family girl
159 (.) you see (.) like your(.5) like (.) like your(.5) father's
160 sister's daughter you see. I was in love with her, you
161 see. So what happened now (.5) that uh:: that day I'm
162 getting married (.) she took me to the back of that hall
163 where I'm getting married (.) in the back of the hall
164 and she sprinkled some dust on me (.) and I had a
165 new suite on and I told her "Aunty, aunty why you
166 dusting this thing on me" you know? She reckon "No
167 don't worry" and after that when she sprinkled the
168 dust then I:: start (.) from that time (.)I'm not (.) you
169 know (.) I'm thinking negative.
170 3.2 PRaeq Nurse: ((CIS)) Is it? (.5) and even now you still thinking that way
171 (Client:Ja) even if you use the medication?
172 A Client: Ja, I still think (.5) like if you say:: you like me too:: I
173 think to myself "No:: what she likes me (.) what (.)
174 what" so I think (.) I think no good, ja (.) ja (.) You
175 know why? That(.) that muti what she put on my
176 head (1sec)((sounds tearful)) now (.) I mustn't be
177 angry with anybody (.) I must be ((a loud noise near
178 tape)) you see (.) so from that time now I think my
179 ears (.) ears and all it buggered my (.) ears (.5) before
180 I was all right (Nurse:Oka::y) But I take my tablets
181 (.) I stay alright I took my tablets this morning[
182 3.3 Praq Nurse: ((Form)) [Okay now for uh your
183 ***Medication=***
184 A Client: =SISTER (.5) THAT UH::VITAMIN B COM
185 (Nurse:yes) the doctor I think he maybe forgot
186 because normally he give me that, you see [(Nurse: so

Herding

187				you)] with the rush you know(.) with the rush you
188				know maybe he forgot to give me vitamin B co.
189	3.4	PRaID	Nurse: ((ID))	(2sec) Let me see (.) maybe he thought you don't need
190				It anymore.
191		A	Client:	No I (.) I take it regular (Nurse: Is it) he always give
192				me, you see.
193	3.5	PReq	Nurse: ((CIS))	Is it ((Sounds of shuffling paper))(2sec) You haven't
194				Been using it?
195		A	Client:	I:: don't (.) uh:: what sister?
196	3.6	PRID	Nurse: (ID))	She didn't give you the (.) previous month also in
197				February she didn't give you (.) B co (.) and last
198				month he didn't give you B co.So maybe she changed
199				(.) your prescription.
200		A	Client:	Oh:::::=
201	3.7	PID	Nurse: ((ID))	=Maybe you don't need anymore, you're fine on your
202				other medications.
203		A	Client:	Oh::::::=
204				
205	4.1	PRaQ	Nurse: ((CIS))	=Okay um ***how are your children***? Do you have
206				any children?
207		A	Client:	Yes, I have four children.
208	4.2	PReq	Nurse: ((OIS))	And how are they?
209		A	Client:	They're alright (.) they (.) they look after me sister=
210	4.3	PRaeq	Nurse: ((CIS))	=Okay that's nice [Client: They take care] so you
211				don't have any problem with them?
212		A	Client:	No, no problem (2sec) no problem.
213				
214	5.1	PRaQ	Nurse: ((OIS))	Okay(.5) is there ***anything else you want to tell me?***
215		A	Client:	Can I:: read books (.) or something sister?
216	5.2	PReq	Nurse: ((CIS))	Book for?
217		A	Client:	Like any books (.) like the paper (.) newspaper.=
218	5.3	PRID	Nurse: ((ID))	=You can read books (Client: Huh?) You can read
219				books.
220		A	Client:	Oh:: So you'll (.) you'll won't say me I mustn't read
221				books because( )=
222	5.4	PRID	Nurse: ((ID))	=No, you can read books at home (Client: Huh?) You
223				Can read books at home, magazines, newspaper.=
224		A	Client:	=Newspaper and magazines I can read? (Nurse:Yes)

Highlighting

Highlighting

225				You know why I fear, you know you (.) you know why
226				I fear? (Nurse: What you fear?) because you'll all
227				think I've (.) I've got nerve troubles and I uh:: can't
228				read at (all)=
229	5.5	PRa	Nurse: ((ID))	=No (.) I mean (.) if you can read then then do=
230		A	Client:	=No like magazines and papers and all I can read?
231				(Nurse: Yes) You know why I fright (.) you know?
232	5.6	PRaeq	Nurse: ((CIS))	Is it (.) You scared of a magazine? (Client: Huh?)
233				You scared of (.) reading the magazine?=
234		A	Client:	No:: I'm not scared of reading a magazine( ) no (.)
235				I'm scared of you all, like (Nurse: Why?) Like you
236				know if I read magazines and papers just now you
237				stop my grant or something you know Nurse:No)That
238				is what I fear for.
239	5.7	PRID	Nurse: ((ID))	No (.) no it doesn't apply that way (Client: Oh::) you
240				Can read magazines (Client: Oh:::) you can read
241				Newspapers (Client: Oh:::) you can read books.=
242		A	Client:	Oh::: I see (.) you know I'm telling you the facts now
243				(Nurse:Mm) because you know why? I got that nerves
244				now, you see (.) I'm talking (.) I'm talking to you now
245				(.5) if I talk too much, sister then I get nervous (.) see
246				m getting nervous now (Nurse:Okay (.) just take it easy
247				now) you see (.) you see I'm getting nervous now
248				because I'm talking too much to you now (.) right
249				((starts to cry)) I'll stay quiet right=
250				
251	6.1	PraID	Nurse: ((ID))	=Okay (.) Oka::y Okay (.5) uh::(3sec).Your ***visit for***
252				***next month*** is 24th of the 5th [Client:When's that day]
253				of next month. Okay, here is your medication
254				(.)prescription so you can give it to the sister in the
255				front.(Client:Oh::::okay sister) So:: take it easy now=
256		A	Client:	=Okay (.) you see: when I talk too much (.) then I get
257				too like nervous, don't get (.) ja:: I get too nervous and
258				all (.) you see (.) that is why my daughter gave me
259				one room (.) for me to stay there (.) and she's got
260				magazines and all these things, you know. And I've
261				got some plants (.) everytime I look at (.) you see some
262				people (.) they look at a fish tank (Nurse: Mm) some

Highlighting

people look at a fish tank (.) you know they've got a
big fish tank in the room (Nurse:Mm) they look at
that one (.) and they:: meditate on it. Like I got my
plants, now every time a leaf comes out (.)I feel happy
(Nurse:Mm) my daughter gave me one room. She
stays that side (.) I stay this side (hh) and I've got
myself I've got my window if I want to see anything I
see, and I've got my plants and all these things.
(Nurse: O:::kay) thank-you sister (Nurse: Thank you
for talking to me) I'm sorry uh:: to say you (.) I'm a bit
upset= (Nurse: No its fine, its okay) because if I talk
too much (.5) okay, I hope you understand my
sickness Nurse:Okay (.) I understand) Okay then
(Nurse: bye, bye.) Tape Ends

Transcript Number Six (6) **Interview duration: 15 minutes**

Additional transcription notes/details

((This client speaks very slowly with lots of pauses and a stuttering sound which is indicated as "uh:::" . The nurse's tone of voice is paced with that of the client's.))

1	1.1	Q	Nurse: ((OIS))	***How are you*** ((today?)
2		A	Client:	I'm feeling ((coughs)) feeling okay.
3	1.2	PReq	Nurse: ((OIS))	You're feeling oka::y?
4		A	Client:	A bit tired (.) but (.) but that's:: my age (.) I'm
5				Getting older, you know ((laughs)).
6	1.3	PReq	Nurse: ((CIS))	Are you tired e:very morning or (.) every day?
7		A	Client:	Uh (.5) No (.) no:: I get (.) energy you know but
8				m (.) I'm almost 65 (.) at retirement age now so
9				((laughs)) I get tired (.) you know.
10				
11	2.1	PRaQ	Nurse: ((CIS))	(2sec) Mm:: Okay you get tired (.) ***do you come***
12				***here every month (1sec) for your medication***?=
13		A	Client:	=Yes.
14	2.2	PReq	Nurse: ((CIS))	I see you um: you are only on tablets?
15		A	Client:	And injections=
16	2.3	PRaeq	Nurse ((OIS))	=And injections (.) how is it treating you?
17		A	Client:	Um:: ((coughs)) To (.) to (.) uh::: to to to tell you
18				the truth(.) um (2sec) I haven't noticed any
19				difference (.) you know (.) As a:: (.) as a (.)
20				matter of fact uh::: I believe I am a stable
21				person (.5) and I should be taken off ((laughs))
22	2.4	PRaeq	Nurse: ((CIS))	Ja:::: (.5) so you're okay with this medication?=
23		A	Client:	=Ja=
24	2.5	PReq	Nurse: ((CIS))	=Would you say that it is helping you? =
25		A	Client:	=I suppose so, ja=
26	2.6	PReq	Nurse: ((CIS))	=((laughs)) You suppose?
27		A	Client:	(.)Ja=
28	2.7	PReq	Nurse: ((OIS))	=Do you know what is uh:: what (.) what you
29		are		
30				Taking this medication for?=
31		A	Client:	=Ja (.) yes=
32	2.8	PReq	Nurse: ((OIS))	=Can you tell me about it?
33		A	Client:	Well uh:: for schizophrenia [Nurse: Okay] and
34				for uh::(.) uh:: moods, Uh uh you know, mood
35				changes.
36	2.9	PReq	Nurse: ((OIS))	When was the last time you had uh (.) these
37				Mood changes?
38		A	Client:	(3sec) uh:: no (.5) a lo:ng time ago now [Nurse:
39				Long time?] cause I've been stable ((laughs
40				softly)).
41	2.10	PRaeq	Nurse: ((CIS))	So I will assume that this medication helps

42				[Client:Ja] O:h, okay. Does it? =
43		A	Client:	=Ja=
44				
45	3.1	PRaeq	Nurse: ((OIS))	=(.) Uh:: HOW is your (.) your ***sleeping or (.) your eating***?
46				
47		A	Client:	uh:: (4sec) No I don't think so (2sec) I've never (.) I've never been a good sleeper (.5) you know.
48				
49				I (.) I can't get much sleep. I lie awake at night.
50	3.2	PRaeq	Nurse: ((CIS))	O::h (.) okay. Then how many hours do you sleep at night?
51				
52		A	Client:	(3sec) Five hours at the most (Nurse: Five?) Sometimes three.
53				
54	3.3	PReq	Nurse: ((CIS))	At what time do you go to bed?
55		A	Client:	Ten.
56	3.4	PRAeq	Nurse: ((CIS))	Ten? Then wake up when?
57		A	Client:	(3sec) u::m (5sec) six or eight, you know (.) ja.
58	3.5	PRaeq	Nurse: ((CIS))	Six or eight hmm [Client: But it takes me] but
59				that is more than five hours hey?=
60		A	Client:	=No it takes me a long time to get to sleep.
61	3.6	PRaeq	Nurse: ((CIS))	O::h, oka::y. You go to bed but you don't like (.)
62				s:leep straight away. I see (.) I see (2sec) And
63				you are on sleeping tablets?
64		A	Client:	No, I don't like them.
65	3.7	PReq	Nurse: ((CIS))	You don't like them?
66		A	Client:	They give me bad dreams.
67	3.8	PRaeq	Nurse: ((CIS))	O::h (.) okay. So you don't have those bad
68				dreams anymore because you don't take
69				sleeping tablets?
70		A	Client:	Ja.
71				
72	4.1	PRaQ	Nurse: ((OIS))	I see. Isn't there anything that might be like
73				(.)**worrying you** that uh:: can make you not to
74				sleep at night?
75		A	Client:	Ja, money ((laughs)).
76	4.2	PRaQ	Nurse: ((OIS))	Ah:: that's what's worrying you (.) money. Tell
77				me more about it.
78		A	Client:	Well (.) um:: you know um I (.) I (.) I don't have
79				grant. I've got a work pension, you know
80				[Nurse: O::h, okay]uh:: and um uh::: it's::: it's
81				not really enough (2sec)because the cost of
82				living has gone up so much. ((Laughs))
83	4.3	PRaeq	Nurse: ((CIS))	I understa::nd (3sec) ri::ght. So you depend on
84				this uh: money for survival?
85		A	Client:	Ja.
86	4.4	Prq	Nurse: ((CIS))	Who are you staying with?
87		A	Client:	(2sec) Alone.
88	4.5	PRaQ	Nurse: ((CIS))	O::h, okay (.) I see (.) (2sec) I see (.) and ww:::

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Hectoring

89				are you s::till s::taying uh::: (6sec) what's this
90				(names the place).
91		A	Client:	O::h, no::, no:: (Nurse: Names the place) no
92				that(s)was long ago.
93	4.6	PReq	Nurse: ((CIS))	Where are you staying now? (Client:Beach
94				front) In a flat=?
95		A	Client:	=Hotel=
96	4.7	PRa	Nurse: ((Form))	=A hotel ? Wow:::.=
97		A	Client:	=(.5) but it's um (.) I (.) I got the room CHEAP.
98				They gave it cheaply to me.
99	4.8	PReq	Nurse: ((CIS))	How (.) how much this (.) if I may ask?
100		A	Client:	Seven fifty.
101	4.9	PRaQ	Nurse: ((CIS))	O::h, okay (1sec) I see (3sec) Do you:: like (.)
102				do you have any other means of (.) you know
103				like ((work)) (.)Rather than (.) receiving this::
104				pension?
105		A	Client:	Uh:: no (.) I'm:: trying to get the (.) you know (.)
106				I've tried for uh:: jobs (.) you know (1sec) but uh
107				(2sec) no luck.
108	4.10	PReq	Nurse: ((OIS))	You're still looking for a job? (Client: Mm:)
109				What kind of jobs are you:: (2sec) looking for?
110		A	Client:	Well ((coughs)) I can drive taxis (.) or trucks
111				(Nurse: Oh, okay) I've got a licence (.) you know
112				(.) I:: (.) I can sell insurance. I know about that,
113				you know ((clears his throat))but uh:: (.5) they
114				don't ((clears his throat again)) (.) they don't
115				like taking (.)people who are old. You know
116				that. ((Laughs softly)).
117	4.11	PRaeq	Nurse: ((CIS))	Mm: ((laughs)) (.) so that won't work out, you
118				believe then (2sec) I mean driving trucks and
119				selling insurance?
120		A	Client:	Well, maybe:: I'll get something (.) I don't know
121				(1sec) you know (Nurse: Okay) It depends of the
122				Lord.
123				
124	5.1	PRaeq	Nurse: ((CIS))	(3sec) So you:: (.) trust (.) ***you a Christian***,
125				right? (Client: Ja) and you go to church (Client:
126				Mm:) every Sunday?
127		A	Client:	Ja.
128				
129	6.1	PRaQ	Nurse: ((OIS))	Okay, I see. And u::m (.) since you are not
130				working (.) are you:: (.) ***what is it that you do***
131				***during the day***?
132		A	Client:	U::m (hh) (5sec) try to keep busy (.) by talking
133				to People about the Lord (Nurse: Oh, okay). I
134				don't like being in the room (.) during the day,
135				you know.I like to be out (Nurse: You're an

Highlighting

Highlighting

136				outdoor person?) Ja.
137				
138	7.1	PRaeq	Nurse: ((CIS))	=I see. (.) then (.) I believe ***you have a lot of friends?***
139				
140		A	Client:	U::m (hh) (.) not really (1 sec) you know.
141				Unfortunately (.5) most of my friends (.) are
142				alcoholics or drug addicts ((laughs loudly)).
143	7.2	Pra	Nurse: ((CF))	O::h (2sec) I see(4 secs).
144		A		I:: (.) I'm not, you know.
145	7.3	PReq	Nurse: ((CIS))	You don't smoke or take alcohol with them?
146		A	Client:	Just smoke (.) just smoke, no alcohol or drugs
147				(Nurse: oh you only smoke) Ja.
148				
149	8.1	Prq	Nurse: ((OIS))	And uh (2sec) have you uh:: (10sec) ((Sound of
150				shuffling papers)) and when was the last time
151				you:: uh:: (2sec) I mean (.) you heard ***strange
152				voices*** or:: (2sec) you know uh (.) ***saw people
153				(.5) who: are not there***?
154		A	Client:	Uh (.) no I don't get that (.) because uh::: my
155				Diagnosis uh:: is(.) is not actually full
156				schizophrenia (.) (Nurse: Mm) it's Schizo–
157				affective (Nurse: Mm) and Dr (name deleted)
158				explained to me (.) that (.) its: (.) it's um (.) it's
159				schizophrenia (.) without the voices and that,
160				you know, it's um (.) it's (.) uh::: I' I I've actually
161				got very mini (.) uh minimal (.) schizophrenia,
162				you know (Nurse: Mm) That's why I want to be
163				taken off (.)medication (laughs))
164	8.2	PRID	Nurse: ((CF))	((Laughs softly)) It's a good thing that you know
165				so: much about your diagnosis=
166		A	Client:	=Ja.
167				
168	9.1	Praq	Nurse: ((CIS))	(2 secs) Ja (2 sec) Have you ever had
169				***thoughts of (.)taking your life away***?
170		A	Client:	Um: ja (.) I have (.5) but everyone gets that,
171				you know.
172	9.2	PReq	Nurse: ((CIS))	How often (.) do you get these thoughts?
173		A	Client:	No (2sec) not (.) not for a long time now.
174	9.3	PReq	Nurse: ((CIS))	How long, if you (.) you can be specific?
175		A	Client:	Uh (7sec) six months ago but (.) uh but you see
176				it's just (3sec) its (.) its just depre (.) depression
177				(.) you know (2sec) I wouldn't really do it
178				(Nurse: Mm) (.) you know.
179	9.4	PRaeq	Nurse: ((OIS))	You (.) you just think about it but (.) you
180				wouldn't do it (Client: Mm, no) Is that what
181				you're saying? (5sec) I see. And (.) if (.) if you
182				happened to have these thoughts (.5) exactly

183				how do you like (.) sort of plan (.) to do it?
184		A	Client:	Uh:: NO (.hh) YOU SEE (.5) uh (.) in (.)
185				depression uh::just (.) um just (.) wish (.) that
186				the Lord would take me and that's all ((laughs)).
187	9.5	PRaeq	Nurse: ((CIS))	O::h (.) I see (.) that you'll wake up dead (.5) one
188				(.) morning?=
189		A	Client:	=Ja ((laughs))
190	9.6	PRaeq	Nurse: ((OIS))	Okay, I understand (.) and you haven't had that
191				uh for:: six months (Client: No) and what now
192				(.) depressing you that uh: will make you have
193				these thoughts?
194		A	Client:	uh: (.)You see um (.) I've got friends (.) that
195				borrow a lot of money from me (Nurse: Mm) I:: I
196				was born (.) a soft touch. You know what a soft
197				touch is? (nurse: Mm) Ja (.) and (.) I::'m too soft
198				with people (.) you know (.) and (.) friends of
199				mine owe me (.) plenty, you know and um uh (.)
200				they keep (.) coming (.) back, you know. I've got
201				one particular friend who keeps (.) coming (.)
202				back, you know. So it depresses me. ((Laughs
203				softly))
204	9.7	PRaeq	Nurse: ((CForm))	I se::e. He borrows your money, he doesn't
205				bring it back, then he comes again (Client: Ja.)
206				Ja, and then it depresses you?
207		A	Client:	Ja.
208	9.8	PRaeq	Nurse: ((OSo))	Uhuh (.) I see and (.) what are you planning (.)
209				what are your plans to like (.) solve uh (.) this
210				problem (2 sec) because it's depressing you?.
211		A	Client:	Oh, ja. To become stronger in the Lord (Nurse:
212				Mm) so I just tell them, "Look you know (.) you
213				(.) you must go to someone else."
214	9.9	Praeq	Nurse: ((OIS))	(3sec) Besides your faith what else protects you
215				from uh: (.)you know these things that uh::
216				affect you negatively?
217		A	Client:	U:m (2sec) I think (uh::) the uh:: (.) the the the
218				Advice I get from the doctors here, you know.
219	9.10	PRaeq	Nurse: ((OIS))	Oh, okay. What else?
220		A	Client:	I've seen the uh:: the psychologist here (Nurse:
221				Oh, okay)and uh (Nurse: You've been
222				counselled?) ja, ja and it's um (.) helped.((Client
223				laughs softly)).
224	9.11	Praeq	Nurse: ((CForm))	That is good (Client: Ja) that is good (.) Oh::
225				okay (.) you're staying alone (.) in a hotel(.) and
226				you receive a:pension (.) from where you were
227				working before? (Client:Ja) right (.)and the
228				problems you ha:ve is uh (.) you having money
229				difficulties because you're not receiving a grant

230				(Client:Ja) that's what you sa:id (Client: Ja) Ja
231				(.) and the other thing bothering you is your
232				friend who keeps on borrowing money and not
233				bringing it back?=
234		A	Client:	=Ja (.) Ja (.) Look (.) uh:: (.) uh:::um (.) I::: (.) my
235				uh::: (.) my pension is not bad, you know. It's
236				more than a lot of people earn , you know (.) um
237				(.) but for my needs (.) it's not enough ((laughs)).
238	9.12	PReq	Nurse: ((OIS))	What exactly are your needs (.) if I may ask (.)
239				Besides paying uh (.) for the hotel room (.) for I
240				guess (.) there's some for food (Client: Mm) (.)
241				what else?
242		A	Client:	Well, I need to uh:: I need to get back in a (.) in
243				a flat, you know (.) uh::: because:: just a room
244				is:: (.) not nice you know (.) I mean to go for
245				years in (.) just a room (.) I couldn't tolerate (.)
246				you know (.) and I don't want a tiny flat. I want
247				a decent flat (Nurse: O::h Okay (.) I see) ja.
248				And of course (.) you know (.) um (3sec) I take
249				people to dinner (.) you know uh (.) uh::
250				sometimes.
251	9.13	PReq	Nurse: ((CIS))	What people?=
252		A	Client:	=Uh:: (.) family.
253				
254	10.1	PRaeq	Nurse: ((CIS))	O::h, okay. (3 secs). So your **family members**
255				are around ((names city))?
256		A	Client:	Uh, very few (Nurse: Oh, okay) most have gone
257				(.) to ((names a city in another province)) or
258				overseas, you know. Um (.) there's very few and
259				uh (.) I like to take them out, you know and u::
260				of course any (.) uh:: any (.) uh:: any man (.5)
261				wants to take a few girls to dinner, and so on,
262				you know (Nurse:Okay) So of course (.) dating
263				costs money too:. ((laughs)).
264	10.2	PRaeq	Nurse: ((CIS))	((laughs)) So you still take people (.) people o::t?
265		A	Client:	Ja ((laughing)).
266				
267	11.1	PRaeq	Nurse: ((CIS))	O::h, o:kay. (4 secs) **Do you have a girlfriend** at
268				the moment?
269		A	Client:	Um (.5) No (.) not uh:: not uh:: no not a fixed (.)
270				permanent (.)relationship.
271	11.2	PRaeq	Nurse: ((CIS))	O::h, okay (.5) I see. Have you um (.) been
272				married before? (Client: No) No children (.) I
273				assume? (Client:No) O:h, okay.
274		A	Client:	I should have been (.5) you know (.5) uh:: like I
275				Had opportunities to be, you know (.5) um
276				(2sec) but I messed it up (Laughs)) [Nurse:It
277				didn't work out?] Uh:: no.

Highlighting

Highlighting

278				
279	12.1	PraQ	Nurse: ((OIS))	Okay (2sec)and is there ***anything you'd like us to discuss?***
280				
281		A	Client:	Uh:: No, not really, we've been through most.
282	12.2	PRaID	Nurse: ((ID))	Mm:: O::kay. Then I'll have to give you a date for ***your next appointment*** (Client: Thanks).
283				
284			Tape ends.	
285				

Transcript Number Seven (7) **Interview duration: 10 minutes**

Additional transcription notes/details

((The main nurse-interviewer speaks quickly and interrupts the patient. The interview room is possibly shared with another interview because other voices are in the background.))

1.1	Q	Nurse: ((OIS))	***How are you this morning?***	Highlighting
	A	Client:	Ja, okay. I am feeling a bit better with the medication.	
1.2	Praeq	Nurse: ((CIS))	((10 sec) Cell phone ringing; nurses laughing; Papers shuffling)) So you're saying you're feeling much (Client:Better, yes) better since you've been on[	
	A	Client:	[Better, Yes.	
2.1	PReq	Nurse: ((CIS))	Are you still feeling, err, here (.) ***feeling anxious, depressed?***	Herding
	A	Client:	Depressed, yes.	
2.2	Praeq	Nurse: ((OIS))	Oka:y. Um, what brought it about?	
	A	Client:	You see, it was the loss of my husband and my daughter's divorce within the same (.) you know, week. And it was a complete strain into our lives, because she was married for six months and she just, err, came on a holiday, to actually see her father, he was sick. Just for three weeks he was sick and he passed away. And it was just a week and as you know in our Islam that we have to bury ( ) and (.) she also got a divorce, and we were both in the house and [Nurse: in mourning] yes, it was (.)=	
2.3	Preq	Nurse: ((CIS))	=And where is she?	
	A	Client:	She is here. She was married in Pietersburg.	
2.4	Praeq	Nurse: ((OIS))	Oh, shame. Okay, err, what did your husband pass away from?	
	A	Client:	Err, he did have a renal failure. But he had a transplant and he was fine. At the time of death, his lungs collapsed.	
2.5	PReq	Nurse: ((CIS))	So, how long ago has this been?	
	Client:		A year ago. (Nurse: A year?) Hmm.	
2.6	Preq	Nurse: ((OIS))	So, err, how have you been, err, coping?=	
	A	Client:	I was terrible, but, err, I have my days. Sometimes, I'm very very depressed, sometimes I'm okay. (Nurse: Hmm). Ja and I have two other boys as well. The one is in	

48				standard nine, and it was a great change for
49				him as well, he did very very bad last year in
50				school. (Nurse: Is it?) And yet he used to come
51				out first all the time. But after his father's
52				death, and I suppose, you know, with his
53				sister's problems and all, he did very bad, but
54				he's come back to normal this time yes, I've
55				spoken to his teachers, and they said, no, he's
56				come up to the A-level again.
57	2.7	Praeq	Nurse: ((OForm))	Okay: so you're saying that since you've, err,
58				come here, you have seen that, a change (.)
59				U:m, the clinic has actually helped you?
60		A	Client:	Yes, it has helped me, yes.
61				
62	3.1	Preq	Nurse: ((CIS))	Do you feel like, err, ***speaking about your***
63				***problems*** (.) has it been of benefit?
64		A	Client:	Hmm. Not really. But, sometimes it does help.
65				Not really. Not to such a great extent=
66	3.2	PReq	Nurse: ((CForm))	=So would you say talking about it doesn't
67				help?
68		A	Client:	=No, (so) you see what I appreciate, when I
69				have an interview like this, Ido still discuss it.
70				But when I see the doctor, there's no
71				discussion. He doesn't really ask me anything,
72				or do (anything) (.) he just[
73	3.3	PReq	Nurse: ((CF))	] you feel like he's just
74				(doing his job), he doesn't care about you?]
75		A	Client:	[Yes. He's
76				just, err, he just ask me, is the medicines
77				okay? Will you continue with the same one?[
78				Nurse: That's not fair] and that's it. <u>That's it</u>.
79				Nothing else.
80	3.4	PRaID	Nurse: ((ID))	Okay. You must always realise that we are
81				here to help you. If you can't speak to us, um,
82				it's like, you're not going to be of benefit to
83				yourself. From my personal experience,
84				speaking about it, I promise you, it like, lifts
85				up a burden, and at the end of the day, you feel so
86				much more better and at ease (Client: Yes).And as
87				much as we have our problems and our ups and
88				downs, speaking about it, praying, you know? It
89				really helps. Together with the medication, you know
90				(Client:yes).'Cause, I mean, as you were saying, it
91				does, help you (Client: Yes, it does). And we all have
92				our ups and downs in life. Life is not fair. But just
93				that it's the way we go about coping with it that
94				actually makes a (.) difference to our lives. And who
95				you actually speak to about it. Like, w::e all are here

Hectoring

96				like, I am, I am, as I sit across you, I (.) you may
97				think, like, I have no problems in my life, I am I am
98				fine. But each one has their problems of their own,
99				and you just learn to deal with it in a different way.
100				That's what we need to do. If you're feeling anxious,
101				depressed, just find ways, you know, in which we
102				can overcome them. Like, keeping busy,like, in your
103				case, like you're Muslim, in my case as well, I pray.
104				And praying is so important. And other alternatives,
105				like cook, clean, talk to your kids, you know? Like, if
106				you are feeling the loss of your (.) husband, your kids
107				are there to make up for it. You know what I'm
108				saying? (Client:Yes).And always think that you have
109				them with you. They have so much love=
110		A	Client:	=Yes that's true=
111				
112	4.1	Prq	Nurse: ((CIS))	***=But you're eating well, you're sleeping well?***
113				
114		A	Client:	Yes.
115	4.2	PReq	Nurse: ((CIS))	No problems at all?
116		Client:		No, nothing. It's just, err, I actually fall asleep
117				only after I taken the medication. Otherwise
118				I don't sleep. And when my sleep is disturbed,
119				maybe if a child comes and wakes me up, or if
120				there's a phone call, then I find it very
121				difficult to go back to sleep. Nurse: Okay). But
122				I do sleep well.(Nurse: Is it?). And I do my
123				housework, my cooking (.) everything I do. I
124				drop my kids. My daughter is working. I drop
125				her at work. I drop my son at school. (Nurse:
126				You drive?) I drop and pick up and I do all
127				that.=
128	5.1	Q	Nurse: ((CIS))	=***Are you working?***=
129		A	Client:	=No (.) unfortunately, I've been suffering - I
130				can't get work. I have tried many places, but I
131				keep myself occupied with the housework
132				(Nurse: That's good, that's good).I don't have a
133				maid [
134	5.2	PRaID	Nurse: ((ID))	[=Hmm. That's very good. At least you
135				have alternatives, that's excellent you [know?
136			A Client:	[I do all
137				the work myself.
138				
139	6.1	PRaQ	Nurse: ((CIS))	***So, err, where are you from?***
140		A	Client:	From ((names place)).
141	6.2	PRaeq	Nurse: ((CIS))	And, err, coming here, do you come with the
142				bus?
143		A	Client:	I drive. I've got a car.

Herding

Herding

Highlighting

144	7.1	PRaQ	Nurse: ((CIS))	Okay. There's no like, ***side effects of the medication***?
145				(Client: No). Nothing at all? (client: Nothing)
146				your'e seeing doctor this visit? (Client: Um..)
147				Doctor who? X (Name deleted) (Client: No.
148				Um..) (papers shuffling) (Client: ???) No, it's
149				fine, it's fine! We all forget at times. (..) Dr
150				((X)). (Client: Ja.).
151				
152				
153	8.1	Q	Nurse: ((CIS))	(2 sec) Have you ***opened your, err, business as yet***? It says here on the file.
154				
155		A	Client:	No.
156	8.2	PReq	Nurse: ((OIS))	What are you actually wanting to do?
157		A	Client:	My father said we must come to ((city in
158				another province)) where he is and open up
159				something, he'll help us, but the children
160				don't want to go, they say it's a great
161				adjustment.
162				
163	9.1	Q	Nurse: ((CIS))	Okay (3secs) um::: So your (.) How old are
164				your **boys?**
165		A	Client:	My one has just turned sixteen years, the
166				other one is eighteen, and my daughter is
167				twenty-one.
168	9.2	PReq	Nurse: ((CIS))	And they all live with you?
169		A	Client:	Yes.
170	9.3	PReq	Nurse: ((CIS))	Have they been, err, supportive?
171		A	Client:	Um, ja they are. But there's times when they,
172				when they do give me a lot of problems in the
173				sense that, when their father was around, he
174				afforded everything for them. He really spoilt
175				them. They all had their cell phones, they
176				could go where they want to, and spend
177				what they want to, he used to give it to them.
178				And now that they can't have it, they do
179				trouble me. In the beginning, my son used to
180				go away, and, you know, was very very
181				depressed, he felt he's in his father's
182				place, now he'll have to look after us,
183				financially as well. Whereas we didn't
184				pressurize him with that, and then, he was
185				very depressed and some of his friends, y
186				you know, got him hooked onto drugs, and (.)it
187				was terrible. But he's fine now. For the past
188				three months, he hasn't, he's not even going
189				out with those friends or anything. That was
190				an extra problem onto us (Nurse: Ja) but it's
191				okay now.

192	9.4	PReq	Nurse: ((CIS))	Have you, err, spoken with him?
193		A	Client:	Ja, he goes to SANCA for counselling.
194	9.5	Praeq	Nurse: ((CIS))	O::h, okay (.) Is he, err, better now?
195		A	Client:	Much better.
196	9.6	PReq	Nurse: ((CIS))	Have you seen a change?
197		A	Client:	Yes, definitely. He's ( ), he's ( ) now ( )
198	9.7	PRaeq	Nurse: ((OF))	I see it's making you depressed speaking
199				about him. It's okay to cry (..) This is the boy
200				that is? Sixteen? (Client: Seventeen.)
201				Seventeen?
202		A	Client:	He'll turn eighteen this month.
203	9.8	PRaeq	Nurse: ((CIS))	Okay. And where is he, oh he's at home.
204		A	Client:	At home, ja.
205	9.9	PReq	Nurse: ((CIS))	Do you know, like er, how he got hooked onto
206				these, err, drugs?
207		A	Client:	Ja, it was when he just lost his father, and
208				then his sister's problem and then he was very
209				depressed, it was one or two of his friends and
210				then he's feeling so down, he's crying. And
211				they dashed his drinks and he felt better. And
212				then he asked them what it is, he said to me
213				give it to me again and that is how it went.
214				And then we noticed [Nurse:And what was it?]
215				I don't know what it was. And we noticed
216				that he wasn't himself. He came home, was
217				fine and then (.) he was awake for day and
218				night. He didn't sleep. And then when he
219				slept, he slept on for two days and it was
220				terrible. And then I spoke to my, our family
221				doctor, and hespoke to him as well and that's
222				how I went to SANCA with him and Mrs
223				((name deleted)) has been seeing him from
224				that time and (???) [Nurse: That's good, that's
225				lovely] and my parents spoke to him, and then
226				they see me so depressed, I cried when I spoke
227				to him, you know? It has helped. And I
228				stopped him[
229	9.10	PReq	Nurse: ((C Form)	]At least he got that help in time]
230		A	Client:	[and I
231				stopped him completely from
232				going (Nurse:lovely) with those friends=
233	9.11	PRID	Nurse: ((C Form))	=You should be very proud of yourself and not
234				crying (laughs softly)). Because, the mums, I
235				promise you, out there, if, I mean, you are
236				going through your own (.) depression and
237				loneliness and things, they just leave their
238				kids, they don't worry about them. At least

239				you have the strength, to like, you know,
240				oversee your, err, older son, and get him help.
241				It's lovely. You should be very proud of
242				yourself. It's very good. Yes the main thing is
243				keeping your family intact.(Client: That's very
244				important) and that's what you should be
245				focusing on, I see you have been doing that,
246				it's lovely, it's very nice. (2 secs) On the whole,
247				I think you are doing fine (.) The medication
248				helping you, and you look well.
249		A	Client:	Yes, no, I'm feeling much better.
250	9.12	PRaID	Nurse: ((CF))	It's lovely. Just, just hang in there, and, just,
251				err, just pray. Prayer is so important, you
252				know?=
253		A	Client:	=Yes, I pray that things will only get better. I
254				just keep praying (.)=
255	9.13	PRID	Nurse: ((CF))	=and God has a reason for everything, I
256				strongly believe in God.
257		A	Client:	That's true.
258	10.1	Q	Nurse: ((OIS))	(.) ***An::ything (.) else you want to talk to me***
259				***about***, anything that's troubling you?(Client:No,
260				everything's okay) Anything about your diagnosis
261				that you want to know more about?.
262		A	Client:	=No, nothing.
263	10.2	PRaeq	Nurse: ((CIS))	You're fine? (Client: Yes, thanks). So on the
264				whole you are (doing well)?
265		A	Client:	Thanks so much, yes.
266				
267	11.1	PRaID	Nurse: ((ID))	(3 secs) Okay. ***Your doctor's appointment is***
268				***next month***.
269		A	Client:	But I was there last month and I've seen
270				doctor. And, when I see the card, I was also
271				surprised how come I see him so quickly.
272				Because last month I've seen doctor. Because
273				I'm supposed to see him once a month, isn't it?
274	11.2	PRID	Nurse: ((ID))	I don't think its once a month, no, okay then=
275		A	Client:	=Thank-you. Tape ends

Herding

Highlighting

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RESEARCH ETHICS COMMITTEE

Student: L.E. MIDDLETON

Research Title: A social constructionist analysis of psychiatric nursing in the student nurse-client psychiatric clinic interview

A. The proposal meets the professional code of ethics of the Researcher:

YES NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: _____ Date: 21/11/2002

Signature of Supervisor: _____ Date: 29/11/2002.

Signature of Head of School: _____ Date: 9/12/2002

Signature of Chairperson of the Committee: _____ Date: 3/12/02
(Professor ~~S P Henzi~~)
A Todes
(Vice-Chair)

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