Hedmark University College

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This is the author's version of the article published in

Ethical Human Psychology and Psychiatry

The article has been peer-reviewed, but does not include the publisher's layout, page numbers and proof-corrections

Citation for the published paper:

User Experiences of Different Treatment Cultures in Mental Health Care

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Background: Clients have mixed experiences with mental health services. Historically there have been quite different and also incompatible approaches to treatment in mental health care. Some antagonisms may have been overcome, but clients' experiences still seem to mirror approaches that are in contrast to each other. Aim: To describe different treatment approaches as clients experience them, discuss essential factors in, and differences between the approaches and the degree to which they appear corresponding or antagonistic. Method: Qualitative content analysis of stories from approximately 492 users dealing with positive, negative, or both positive and negative experiences with the health service system. Results: Clients experience different treatment cultures side by side within the mental health care system. The cultures exist on a continuum where monologue and dialogic cultures represent endpoints. Conclusion: It is important to acknowledge the contrasts clients have experienced between different treatment cultures. Realizing the contrast between approaches, it emerges as important that clients are given a choice and can get the kind of treatment they prefer.
Keywords: mental health care; user experiences; treatment culture; monologic and dialogic approaches

T his article deals with user experiences and the kind of help they have received

from the mental health care system, which means that treatment approaches are assessed from clients' points of view.

Treatment approaches may be seen as manifestations of treatment cultures, but also as refl ections of organizational cultures. Organization culture refers, among other things, to kinds of leadership, structure, communication, ability to make changes, fi nance and human resource management (Braithwaite et al., 2005), or fundamental assumptions about reality and the nature of human beings, manifested in values and observable actions (Scott-Findlay & Estabrooks, 2006). Organization cultures are also studied with regard to the facilitation of changes toward a patient-centered model (Scott, Mannion, Davies, & Marshall, 2003). This last example illustrates that there is not a sharp distinction between therapeutic culture and organization culture. But organization culture has a wider organizational focus. In this article the narrower concept treatment culture will be used, referring to beliefs and values, attitudes and practices, that is assumptions about human nature, attitudes toward mental disability, client-centeredness, client involvement in therapeutic decisions, dialogue, and communication.

To some degree treatment culture may also be seen as overlapping with professional culture, but the use of professional culture implies discussions about professional properties versus local professional cultures, and also about the sources of different cultures. Are the cultures effects of professional training or local values? As the main question in this study is not distinctions between different professional groups, the concept treatment culture is seen as preferable to professional culture in order to characterize the phenomenon that is studied.

AN OUTLINE OF LITERATURE DEALING WITH

TREATMENT CULTURES

Studies dealing with ideology and culture in the mental health care system have a long tradition. In the 1950s and 1960s there was much focus on change processes; how treatment cultures defi ned as custodialism could be replaced by humanistic oriented approaches (Goffmann, 1961; Greenblatt & Levinson, 1957; Johansson & Israel, 1965; Löchen, 1976; Pearlin, 1962a; Perrow, 1965). In order to overcome barriers against change, it was seen as important to increase the nursing personnel's allegiance to the humanistic ideas (Coser, 1958; Pearlin, 1962b; Perrow, 1965). Further investigations showed how institutional frames, roles, and restrictions confl icted with more human, individualized treatment. Löchen (1976) studied a hospital ward where traditional treatment was replaced by milieu therapy with focus on individualized treatment, freedom, and time to be with clients, but where therapy aims confl icted with security arrangements and workload. The answer to the dilemma was the diagnostic culture, which meant that all restrictions, even those that followed from security routines and workload, were given milieu therapeutic reasons.

Coyle (1997) and Williams and Grant (1998) identifi ed similar confl icts decades later and found that outside institutions' administrative routines and responsibilities interfered with ideals of person-centered practice. Still, this is about administrative routines as barriers to individualized treatment and not directly about humanism as opposed to custodialism. To some degree the old antagonisms seem overturned and replaced by a broader repertoire of approaches. But we also have studies where reminiscences of old opposites are documented. Latvala and Janhonen (1997) have observed and interviewed nurses, clients, and students and identifi ed an approach showing resemblances with what was earlier defi ned as custodialism. This approach to psychiatric nursing was defi ned as confi rming–controlling and the researchers claimed that this treatment culture still plays a dominant role in institutional treatment. The opposite approach was defi ned as catalytic, which concentrated on collaboration in order to achieve a benefi cial change for the patient. The researchers also defi ned a third in-between type of psychiatric nursing called educating, which focused on teaching the patient to manage daily life and self-care. Lindström (1997) studied cultures and care-relations between nurses and clients and found a broad spectrum of treatment approaches, ranging from positive, safe relations to relations marked by distance, unclearness, and anxiety. In the last case clients experienced loneliness, a kind of vacuum and infringements. One quarter of the clients in Lindström's study reported experiences of disrespect. Examples were tactless routines for pill distribution, restricted access to the kitchen, informal compulsion, execution of power, and staff behaving toward clients as if they were not capable of independent thinking. The nursing ideal set up in contrast to distance and infringements was *being with* in safe and caring environments.

In a résumé of international psychiatric nursing research, Hummelvoll (1998) found two different approaches to clinical practice:
1. A holistic, existential orientation based on revitalizing basic humanistic values.
2. A traditional scientifi c, medical–psychiatric orientation precipitated by biomedical research.

Hummelvoll's distinctions here correspond to Wampold's (2001) descriptions of two main traditions in the fi eld of psychotherapy: the contextual and the medical approach. The contextual approach signifi es individualized therapies where good relations are highly valued. According to Wampold this tradition is in confl ict with the medical model with its weight on manualized therapy. He further argues that the ability to make clinical judgments is also impaired by manualized therapy. Walker & Read's (2002) distinction between the biogenetic models as opposed to a psychosocial model corresponds in a large degree to the different approaches described by Wampold and Hummelvoll. They further illustrated how causal beliefs have consequences when it comes to attitudes and service design. Lester and Gask (2006) have elaborated this thinking by pointing to the connection between a collaborative approach and models of recovery, while models of medical care delivery are based on the notion of chronic illness.

Concepts and confl icts related to treatment cultures have changed over time, but also have resemblances to each other. Below is an overview and a summary.

Different paired concepts used about treatment cultures:
• Humanism and Custodialism
• Milieu therapy and Diagnostic cultures
• Client-centered, individualized treatment, and Manualized therapy
• Recovery, collaborative approach, and Medical care delivery
• Psychosocial and Medical, biogenetic understanding
• Catalytic (and Educative) and Confi rming–controlling attitude

• Caring, safe, helpful relations and Unclear, distant, anxious staff
• Being with as principle and Distance, infringements.

AIM
The aim of this study was to identify variations in therapeutic cultures as clients experience them, with a special focus on what constitutes the cultures, differences between them, and the degree to which they appear as antagonistic and how unanimous they seem to be.

METHOD
An underlying assumption in this study is that rationality can be sought through the language, and that the telling and retelling contribute to the development of new stories, new understanding, and new socially constructed realities. In this construction our facts are grounded (Mattingly & Garro, 2000). In a constructivist, as well as hermeneutic frame of understanding, the standpoint is the point of departure for a critically directed rationalism (Kjørup, 1989).
Whether we talk about constructed truths or interpreted realities, it is of crucial importance to grasp the other's concepts and schemes. To grasp these schemes a narrative perspective was chosen. This perspective is infl uenced by social and human sciences where texts are treated as windows into human experiences (Silvermann, 2000), and analyzed in order to disclose essential properties and different discourses operating in the fi eld of mental health care.

INFORMANTS
The data was selected from a larger study carried out in cooperation between the main researcher and Mental Health Norway (MHN), the largest user-organization in Norway. The organization has a good relationship with the government and also a well-developed administration that could facilitate the collection of data. In the period of data collection, there were about 5,000 members spread over the whole country. About 4,000 of them, chosen randomly, [1] were invited to take part in the study. Nearly one-fi fth responded. Of these about 492 [2] (151 men, 341 women, aged 19–90 years) answered one or both of the open questions at the end of the questionnaire. These informants have experiences from all parts of the mental health system—traditional psychiatric institutions, out-patient clinics, day centers and individual therapy. Of these, 67% had disability pension, 13% had jobs, and 20% combined disability pension with jobs or studies.
The material consists of stories written in response to the two open questions.
1. Would you like to tell a story from a special meeting with a helper or a health service system that meant a turning point [3] in your life?
2. If you have had strong negative experiences, would you like to describe such an event?
Of the 492 persons who answered one or two of the open questions, 157 persons wrote only a positive story, 112 only a negative, and 223 reported both a positive and a negative story; in total, 715 stories.
As a result of an unsystematic list of members, extensive dropout, and insuffi cient knowledge about the organization's member profi le, statistical representativeness related to the organization cannot be claimed. Statistical representativeness related to mental health clients in general is even more doubtful, as only a rather small portion of mental health clients are organized. Nevertheless, distribution by gender, age, disability pension, education and job, and the fact that the informants have experiences from all parts of the health care system, indicate trustworthiness in the way that the experiences and the chosen categories are applicable for several groups of people.
The narratives vary in length from one line to several pages. The long stories often give in-depth information about background, causes, experiences, feelings, and concrete elements in the recovery process or the traumatic experiences. Brief reports sometimes contain important information, like "I learned that it was possible to trust people." Other stories do not reveal essential information. For example: "It was positive to receive help from the health service system." These kinds of utterances were not included in the analysis because meaning content could not be identifi ed. Out of the 715 narrative reports, 610 were seen as informative enough to be included in the analysis. The material is still rich and, most importantly, it is written by persons who have experienced the mental help service system themselves and therefore possess the best qualifi cations to explain what it feels like.

ANALYSIS

The stories were analyzed by means of qualitative content analysis (Graneheim & Lundman, 2004). The stories were read through several times in order to discover themes hidden in the texts and to obtain a sense of the whole. Manifest content in the texts is presented as categories that may also be seen as expressions of the latent content. The presentation of meaning units in categories is based on the researcher's judgments. Premises and procedures are described and then the reader is invited to evaluate if the fi ndings are credible and relevant.

Different ways of categorization were tried and fi nally it emerged that the stories could be analyzed along two dimensions: Degree of treatment alliance (ranging from experienced alliance to experienced confl ict) and degree of psychosocial orientation from the part of the therapist (ranging from experienced instrumental treatment to experienced psychosocial or contextual approach).

A detailed matrix was created with the four main categories (Table 1) and several subcategories, and were placed according to concrete qualities in the positive or negative experiences. For the process of analysis, a scheme was constructed with 40 subcategories and even with descriptions of different qualities of experiences within the same subcategory. References were made to all the narratives in this scheme.

Stories where meaning content could not be identifi ed were categorized under "general positive experiences" or "general negative experiences" and usually excluded from the analysis.

Several stories contain a number of different elements or meaning units: for example instrumental help, talk therapy, network and spiritual experiences woven together. It was seen as important to let each story represent itself in just one subcategory. The most outstanding feature in the text determined the subcategory to belong to. As the subcategories were made exclusive it was easier to give an overview of the material and the distribution of items related to individuals. At the same time this procedure does not pay justice to the richness of the material. Methodologically it means that the empirical data behind the categories is far more comprehensive than the categories demonstrate.

In the categorization process the content was condensed (Graneheim & Lundman, 2004), while in the extracts from narratives the content communicates by its own virtue (Spiggle, 1994). The extracts also illustrate nuances that disappear in the categorization. The categorization process can be illustrated by the following example: Client tells:

I felt there was too much pressure on me to take medicines, no time to wait until I was ready to deal with my problems. I had a lot of sorrow inside over a lost childhood. This was generalized to: "Childhood /trauma rejected" and categorized under "lack of alliance" in an "instrumental– medical" setting.

TABLE 1. Experiences of Alliance and Confl ict in Different Professional Settings

Medical Approach

Medical–instrumental help experienced as benefi cial (*n* = 18)	*Experienced rejection and isolation in treatment context*
Benefi cial medication practice	—not taken seriously
—medicines and following up	—rejection, lack of treatment
—medicines that functioned okay	—just stored away, no following up
—helped to reduce medicines	*Strain caused by treatment*
Diagnosis experienced as a relief	—medicines abruptly removed
—enough time for diagnosis	—negative side effects of medicines
—diagnosis and following up	—wrong diagnosis
The experience that service is available	*Disrespect and threat to integrity*
—access to hospital	—compulsion, punishment
—hospital as a place of refuge in crisis	—treated violently
Medical–instrumental help experienced as threatening and humiliating (*n* = 225)	—accusations, infringements

Psychosocial Approach	
Positive experiences with psychosocial and social help and support (*n* = 297)	**Rejection and negative encroachment in therapeutic relations with a psychosocial focus (*n* = 70)**
Traumas worked through	*Bad communication*
—working through traumas	—miscommunication
—obtained self-insight	— no understanding
—a new start and quality of life	*Client's dilemma rejected*
Experienced community	—childhood–/ trauma rejected
—trust, confi dence, feeling of worth	—persuasion to divorce
—spiritual experiences	— children not cared about when parents were
—peer support and network	sent to hospital–received help
Welfare–socioeconomic help	*Unethical behavior from the therapist*
—practical help	—inappropriate behavior from the therapist
—housing and activities	—appointments not respected

ETHICAL ISSUES

The project is registered at the Norwegian Social Science database (NSD) that has delegated authority from the Data Inspectorate of Norway to accept investigations where sensitive, personal information is involved. The collecting of data was organized in such a way that the researcher was unable to identify the informants. Letters were sent to the members of the user organization (MHN) directly from the MHN's secretary, after the project had been discussed in the MHN's executive committee. In practice this means that the user organization had ownership to the investigation and asked its own members to participate.

Answers were returned anonymously to the researcher. Because the questionnaires were sent by mail, and the right not to participate was underlined, informants' informed consent was taken care of and also the right to privacy and integrity. There were no cases where informants told about any discomfort by being asked to fi ll in the questionnaire or tell about positive or negative experiences. But some informants stated that they were unwilling to tell about bad experiences. Reasons given for this were, for example, the telling would open old wounds. Several informants expressed that it was a relief to be able to write down their stories.

RESULTS

The material is presented in a matrix so the 610 stories where meaning content could be identifi ed are categorized. As mentioned earlier the categories are made exclusive and categorized according to which aspect seemed most important to the user. The complexity in each individual's experience is not mirrored in the table, but illustrated in extracts from narratives presented after the table. Each subcategory listed in the table is later exemplifi ed by a story and commented on.

Clients' experiences are dichotomized in the table. The open questions in the questionnaire invited such a dichotomizing by asking for a positive and a negative experience. On the one hand this strategy was useful in order to grasp how different treatment cultures may be. On the other hand the informants responded by often writing broad and rich narratives where positive and negative as well as neutral or mixed experiences appeared. Examples are stories where clients tell about stays in hospitals that were experienced as benefi cent because they met good helpers, but where they also felt insulted by some staff members. Such examples illustrate that different treatment cultures are experienced in different service contexts, but also within the same ward or context—seemingly expressed by different actors. In the following, extracts from the narratives are presented and related to different treatment cultures.

MEDICAL–INSTRUMENTAL TREATMENT EXPERIENCED AS BENEFICIAL

The essential elements in stories about positive experiences with mainly medical–instrumental treatment are about benefi cial medication practice, diagnoses, and availability, as illustrated in the following stories.

Benefi cial medication practice:
Woman, aged 51
After 4–5 years with diffi culties because of side effects. . . . I saw several doctors–psychiatrists, at last there was one psychiatrist that found another medicine that worked well and I functioned OK in work and leisure-time, even if I was not quite healthy.
Diagnosis experienced as a relief:

Man, aged 38

To be sent to hospital in 1998 meant a positive turning point because I earlier saw myself as a particularly bad person. Instead I found that I was ill and I met several other clients who had similar experiences. My experiences with hospitalization are mainly positive, but I miss being followed up between the hospitalizations.

The experience that service is available:

Woman, aged 45

I saw a psychiatrist in the casualty emergency clinic. He knew me from earlier times and asked: What do you want? What do you think will be of help to you? I told him: To be hospitalized in order to rest, receive care and get motivated to go on in life. I got direct access to the ward for depressed people. I think he showed a lot of empathy this time.

To be offered help—and to experience that help is available—seems of central importance in all these stories. The informants have asked for help and experienced that their requests were taken seriously. Getting a diagnosis and learning that they have an illness also signifies to some people that they are taken seriously. To be given an acceptable explanation for their problems is experienced as a relief.

Medical–instrumental help offered in a client-centered way means that there is an alliance between client and therapist. Alliance seems to be a condition for success, whichever therapy is offered (c.f. Hubble, Duncan, & Miller, 1999).

MEDICAL–INSTRUMENTAL TREATMENT EXPERIENCED AS THREATENING AND HUMILIATING

In this category clients describe rejection, strain caused by treatment, and threats to their integrity, as exemplified in the following extracts.

Experienced rejection and isolation in treatment context:

Woman, aged 61

The staff do not have enough time for the clients. There is no atmosphere of peace. I don't think much has changed over the last 20 years. When we are ill we also feel quite small with quite low self-esteem. This has been my situation for years. Something could have been done to this, but I feel that the staff have too little knowledge about us. And what we tell will not be listened to.

Strain caused by treatment:

Woman, aged 35

I experienced forced medication as an assault where two staff members held me and one gave an injection. Have to admit that to be treated in a psychiatric hospital is experienced as quite difficult because as a psychiatric patient you are not listened to. The injections I got every other week caused me to feel sick and make myself vomit at least twice a week. I told all the time it was the medicines, but was not listened to. This I endured for 4 years. Until finally I got still more side effects and had to drop this medicine and get something else. Then I also stopped vomiting. In my opinion they also have to reduce medicines faster so clients are not over-medicated. I was an inpatient for 14 months and most of the time I slept more than I was awake because the medicines were strong and made me tired.

Disrespect and threat to integrity:

Man, aged 52

I was alone with my life catastrophe that was provoked by a work conflict. Everything had collapsed, job, marriage, faith. I was deeply depressed. All unfortunate conditions cooperated to the total catastrophe. I was handcuffed, put into a cell naked, and transported to hospital. This happened on Friday. Monday I was released. As a man of honor this is the worst thing I have experienced in life (. . .). It took a long time to heal the wounds this doctor inflicted on me (—). Had the doctors I know got the case, this would never have happened. That I know. Today I am remarried and going well.

The stories illustrate how lack of dialogue goes with distance, forced medication, and sometimes violence. These stories also deal with a lack of relating to the client personally. In such circumstances preconditions for identification and empathy with the clients seem weak. If we are not able to identify with the other person, there is a risk of dehumanization (Leer-Salvesen, 2000). Research also indicates that as far as mental illnesses with some brain disorder that needs chemical treatment can be explained, it is easier not to identify with mentally ill persons, and thereby allow a culture that opens up for reification, possibly leading to stigmatization (Walker & Read, 2002). When lack of dialogue goes with an instrumental approach, weak identification with the clients, violations, and views that facilitate labeling and marginalization, we then have a cluster of phenomena that may be summed up as a monologic culture where values, beliefs, or a professional approach do not support equal dialogues as a satisfactory fundament.

POSITIVE EXPERIENCES WITH PSYCHOSOCIAL

AND SOCIAL HELP AND SUPPORT

In this category there are stories about working through traumas, experiencing fellowship, and social and economic support.

Traumas worked through:

Woman, aged 54

In the hospital I took part in body-oriented therapy. Then I got into contact with forgotten experiences from my childhood, experiences that my body remembered. It was a very painful experience and I needed years to heal the wounds. But this experience was a breakthrough in the effort to recover, and many questions were answered.

Experienced community:

Woman, aged 61

The day center saved me. I was met with both care and expectations. We had several activities together and I was also encouraged to go back to work. Unfortunately the day center closed, but we keep in contact with each other and with the leaders and carry on with activities and traveling together. I got friends for life because of the day center.

Welfare–socioeconomic help:

Man, aged 42

After talks in the outpatient clinic I was offered the opportunity to move to sheltered accommodation. This made me able to look forward and look at the brighter sides of life. Earlier I suffered from anxiety and I contemplated suicide. Now there is only some anxiety. I am looking for a job and will also find another flat where I can be more independent.

Experienced alliance, confidence, hope, and material safety characterize this category. Talks, care, and contextual understanding are essential therapeutic modalities. Clients tell how they have been able to build trust in other people and healthy self-confidence.

REJECTION AND NEGATIVE ENCROACHMENT IN THERAPEUTIC RELATIONS WITH A PSYCHOSOCIAL FOCUS

In settings where the therapist has a psychosocial orientation, alliance can be lacking. A psychosocial or contextual orientation does not necessarily imply acknowledgment of the client's own view. Clients have experienced bad communication, rejection of problems and dilemmas, and unethical behavior—also in situations of talk therapy and where contextual factors are recognized as relevant.

Bad communication:

Woman, aged 46

I experienced not to be taken seriously regarding the spiritual aspects of life. The psychologist admitted later on in a letter to a GP that he had not taken this aspect seriously enough. But by then I had left the therapy.

Client's dilemma rejected:

Woman, aged 54

After some time in my new job I felt totally exhausted and was hardly able to dress in the morning. Got an appointment with my GP to have sick leave. . . . Even if I had a good dialogue with my boss, I needed sick leave to restore myself. My GP rejected this, arguing that work was good for me. I rushed down. Felt like I had laboriously climbed a mountain and when I was to take the last step into freedom the doctor kicked me so I fell all the way down. Thinking about my children kept me from suicide. . . . I was dismissed from the job.

Unethical behavior from the therapist:

Woman, aged 37

I was 18 and with quite low self-esteem. The psychologist always wanted to hug me for a long time after the session, and one time he suddenly jumped off the track and asked what kind of sex I practiced.

The stories in this category are characterized by a lack of dialogue between therapist and client. Even if the framing is not instrumental or medical, the alliance is lacking. This finding points to the importance of having a close look at the dialogic meeting itself and not only the cultural or therapeutic context. Dialogue may be lacking even if the professional orientation is humanistic and contextual.

DISCUSSION

In this study clients' narratives in response to dichotomized questions about experiences with the mental health service system have created the fundament for identifying and defining treatment cultures as clients experience them. There are methodological weaknesses related to the fact that the qualitative material, although rich in volume, has limitations when it comes to depth. The data collection procedure did not allow repeated

contact with the informants.

Professional voices are not included in this study, which explicitly takes clients' perspective and where it is seen as relevant to focus on clients' experiences of alliance and dialogue alone. A presupposition made in the project is that therapeutic alliance is defi ned as alliance only when perceived as such from the client's point of view.

An objection that may be raised is about clients' qualifi cations to assess treatment cultures. It may be that not all of them have such qualifi cations, but the relevant information here is about what kind of treatment they received—if it was based mainly on medicines and to what extent this treatment was followed up by talks and emotional support. Further there is a focus on situations where clients experienced that their stories were listened to, understood, and their whole life situation cared about. Assumptions about treatment cultures are drawn from quotes connected to such themes.

WHAT CHARACTERIZES THE CULTURES?

The dialogue can be said to constitute the factor that makes a distinction between treatment cultures. On the one hand, most stories about positive experiences are related to dialogue and alliance. Some exemptions exist where availability in the service system, advantages of getting a diagnosis, and the benefi cial effects of social and economic support are underlined. But alliance and dialogue are not counterparts to these factors. On the other hand, lack of dialogue is a core characteristic for situations where clients describe negative experiences, expressed by statements about not being listened to, understood, believed, respected, or taken seriously. When lack of dialogue is so prominent in those stories, it is reasonable to talk about *monologic* treatment cultures as opposed to *dialogic* cultures. In some cases clients have experienced the cultures as rather unambiguous. In other contexts there is a mixture of approaches as well as of positive and negative experiences.

The majority of stories describing a monologic culture are from contexts where treatment was mostly based on medicines, instrumentalism and restrictions on functions, and freedom of movement. But the picture is mixed here. Even monologic approaches can be framed by an orientation toward talk therapy and a contextual understanding.

In Table 1: "Medical–instrumental help experienced as threatening and humiliating" and "Rejection and negative encroachment in therapeutic relations with a psychosocial focus" are characterized by a monologic culture and nonalliance, even if the psychosocial focus should indicate a contextual and dialogic understanding. The upper right part is characterized by alliance and a dialogic culture. To the left the picture is more complex.

There is a kind of alliance as long as client and helper share the understanding that the treatment will help. This shared understanding does not mean that there is a real dialogue. Still, a small number of informants tell about experienced alliance even when there was hardly a dialogue.

From this it follows that needs are different, but in particular that different treatment cultures are not precisely defi ned by concepts like medical–instrumental or psychological–contextual approaches. To distinguish between cultures a closer look at the dialogic encounter itself or the lack of dialogue is needed. But then it must be admitted that treatment cultures also seem infl uenced by fundamental values in the mental health service system as a whole or in local wards or departments.

WHAT SUSTAINS THE CULTURES?

Dialogic cultures are supported by the central role that is given to users' perspective in literature, public discourses, and national white papers. Knowledge about clients' interests is increasing and shows that clients want good and lasting relations, trust, being listened to, believed in, and taken seriously (Borg & Kristiansen, 2004; Williams & Grant, 1998). On the global level there is a broad movement toward more user involvement and infl uence, which also supports the extension of a dialogic culture.

However, several factors can support the existence of a monologic culture and facilitate the establishment of a distance toward the client. The adherence to a biologic–genetic etiology paradigm, where mental disorders are seen as brain dysfunctions, is such a factor (Walker & Read, 2002). By brain dysfunctions a person's capacity for making assessments is affected and hence the capacity to take part in mutual, balanced dialogues is reduced. From this it follows that the person also needs paternalistic care, and when the client does not comply with this, forced treatment may seem legitimated. Arguments in favor of this culture also say that psychiatrists should be upgraded as adequate members of the medical

family, that all psychiatric models should be based on the neurobiological understanding and defi ned as the discipline that is responsible for assessment, diagnosis in accordance with fi xed diagnosis schemes, and medical treatment (Larsen & Hustoft, 2002, Ringen & Dahl, 2002). Such defi nitions do not facilitate dialogic relations.

What can further support the existence of a monologic culture is the clients' apprehension of expert knowledge so specialized that it is beyond the reach of lay people to make judgments about it. The only choice may be to trust this knowledge.

DO WE TODAY FACE NEW CONFLICTS BETWEEN TREATMENT CULTURES?

It may look as if the old confl ict between humanism and custodialism is abolished. It is hardly discussed anymore. The earlier antagonism seems toned down. Treatment not in line with humanistic ideas seems localized outside the western countries while in western countries different treatment cultures exist peacefully side by side and they all have their advocates. By contrast, clients' experiences illustrate that different therapeutic approaches still may seem incompatible and call for greater awareness with regards to antagonisms that may exist in modern mental health service systems. In this article two main approaches are defi ned as dialogic and monologic cultures. These defi nitions provide tools for the analysis of factors that do not promote dialogue-oriented practices. Clients tell that they are not taken seriously and that their words are not listened to. The material illustrates that such experiences are not just exceptions. This being the case it is important to focus on properties in different treatment cultures that facilitate practices where clients are not listened to.

The inclination to give specialized professional knowledge precedence over clients' experiences, desires, and solutions is probably such a property. In the fi eld of mental health this inclination is supported by the frequent reference to "lacking self-insight." Perrow's statement from 1965 about distance in organizations, caused by specialized technology that is controlled or understood only by a small group, is still relevant.

From a humanistic point of view it can be argued that if users are alienated from treatment decisions, the therapeutic cooperation and change process is affected.

A fi rst step to improving the situation for clients who have experienced traumas and humiliations in the mental health service system will be to acknowledge the contrasts they have experienced between different treatment cultures, and as a logical consequence support their right to decide what kind of treatment they wish to receive.

NOTES

1. The intention was to include every second of the 5,000 members and send a reminder to the same sample, but when it came to the second round the organization could no longer identify every second member from the fi rst round. Therefore, in the second round, questionnaires were sent to the 3,000 fi rst members in the new member list. Roughly estimated then, 4,000 members got the questionnaire, approximately 1,500 of them got it twice.

2. The number can not be given exactly because with a closer look it emerged that close to 10 persons had answered the questionnaire twice.

3. The term turning point was given no further defi nition. The respondents answered by reporting everything from a nice meeting, a new car, medicines removed, and to long-lasting processes where they gradually opened up and experienced new freedom and coping in life. Therefore, the answers are interpreted as stories about positive factors or general recovery factors rather than turning points.

REFERENCES

Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental health, 13* (5), 493–505.

Braithwaite, J., Westbrook, M. T., Iedema, R., Mallock, N. A., Forsyth, R., & Zhang, K. (2005). A tale of two hospitals: Assessing cultural landscapes and compositions. *Social Science & Medicine, 60,* 1149–1162.

Coser, R. (1958). Authority and decision-making in hospital. *American Sociological Review, 23* , 56–63.

Coyle, J. (1997). *Exploring the meaning of dissatisfaction with health care: Towards a grounded theory.* Unpublished doctoral thesis, South Bank University, London.

Goffman, E. (1961). *Asylums* . New York: Doubleday.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24,* 105–112

Greenblatt, M., & Levinson, D. J. (1957). Custodialism and humanism in staff ideology. In M. Greenblatt, D. J. Levinson, & R. H. Williams (Eds.), *The patient and the mental hospital* . Glencoe, IL: Free Press.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change. What works in therapy* ? Washington, DC: APA Books.

Hummelvoll, J. K. (1998). *Internasjonalt utsyn: Resymé av forskning og fagutvikling i psykiatrisk sykepleie, Rapport nr. 10* [International review: Résumé of research and professional development in psychiatric nursing, Report #10]. Elverum, Norway: Hedmark University College.

Johansson, S., & Israel, J. (1965). Kustodialism och alienation bland vårdavdelningspersonalen på ett mentalsjukhus [Custodialism and alienation among the nursing staff in a mental hospital]. *Sos Forskning, 2* , 63–77.

Kjørup, S. (1989). *Forskning og samfund: En grundbog i vitenskapsteori* [Research and society: Textbook in philosophy of science]. København, Denmark: Gyldendal.

Larsen, T. K., & Hustoft, K. (2002, October 18). Psykiatri og kompetanse [Psychiatry and competence]. *Kronikk Dagbladet* .

Latvala, E., & Janhonen, S. (1997). Patient's capable of managing: Basic process of psychiatric nursing in a hospital environment. *Vård i Norden, 17* (4), 9–13.

Leer-Salvesen, P. (2000). Profesjonsetiske perspektiv [Professional ethic perspectives]. In A. M. Stoekken & B. Nylehn (Eds.), *De profesjonelle* [The professionals]. Oslo, Norway: Universitetsforlaget.

Lester, H., & Gask, L. (2006). Delivering medical care for patients with serious mental illness or promoting a collaborative model of recovery? *British Journal of Psychiatry, 188* , 401– 402.

Lindström, U. Å. (1997). Patientens upplevelse av vårdkultur och vårdrelation: Motsatsernas dialektik [Users experiences of ward culture and care relations: Dialectics of the antagonisms]. In J. K. Hummelvoll & U. A. Lindström (Eds.), *Nordiska perspektiv på psykiatrisk omvårdnad* [Nordic perspectives on psychiatric care]. Lund, Sweden: Studentlitteratur.

Löchen, Y. (1976). *Idealer og realiteter i et psykiatrisk sykehus* [Ideals and realities in a mental hospital]. Oslo, Norway: Universitetsforlaget.

Mattingly, C., & Garro, L. C. (2000). *Narrative and the cultural construction of illness and healing* . Berkeley: University of California Press.

Pearlin, L. (1962a). Alienation from work: A study of nursing personnel. *American Sociological Review, 27,* 314–323.

Pearlin, L. (1962b). Sources of resistance to change in a mental hospital. *American Sociological Review, 27* , 325–334.

Perrow, C. (1965). Hospitals, technology, structure and goals. In J. G. March (Ed.), *Handbook of organizations* . Chicago: Rand McNally.

Ringen, P. A., & Dahl, A. A. (2002). Modeller og trender i psykiatri: Bør nevrobiologi danne en felles basis? [Models and trends in psychiatry: Should neurobiology be the common fundament?] *Tidsskrift Nor Lægeforen, 20* (122), 2024–2027.

Scott, T., Mannion, R., Davies, H. T. O., Marshall, M. N. (2003). Implementing culture change in health care: Theory and practice. *International Journal of Quality in Health Care, 15* , 111–118.

Scott-Findlay, S., & Estabrooks, C. A. (2006). Mapping the organizational culture research in nursing: A literature review. *Integrative Literature Reviews and Meta-analyses,* 498–513.

Silvermann, D. (2000). Analyzing talk and text. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* . Thousand Oaks, CA: Sage.

Spiggle, S. (1994). Analysis and interpretation of qualitative data in consumer research. *Journal of Consumer Research, 21,* 491–503.

Walker, I., & Read, J. (2002), The differential effectiveness of psychosocial and biogenetic causal explanations in reducing negative attitudes toward "mental illness." *Psychiatry, 65* (4), 313–325.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods and fi ndings.* Mahwah, NJ: Lawrence Erlbaum Associates.

Williams, B., & Grant, G. (1998). Defi ning people-centeredness: Making the implicit explicit. *Health and Social Care in the Community, 6* (2), 84–94.